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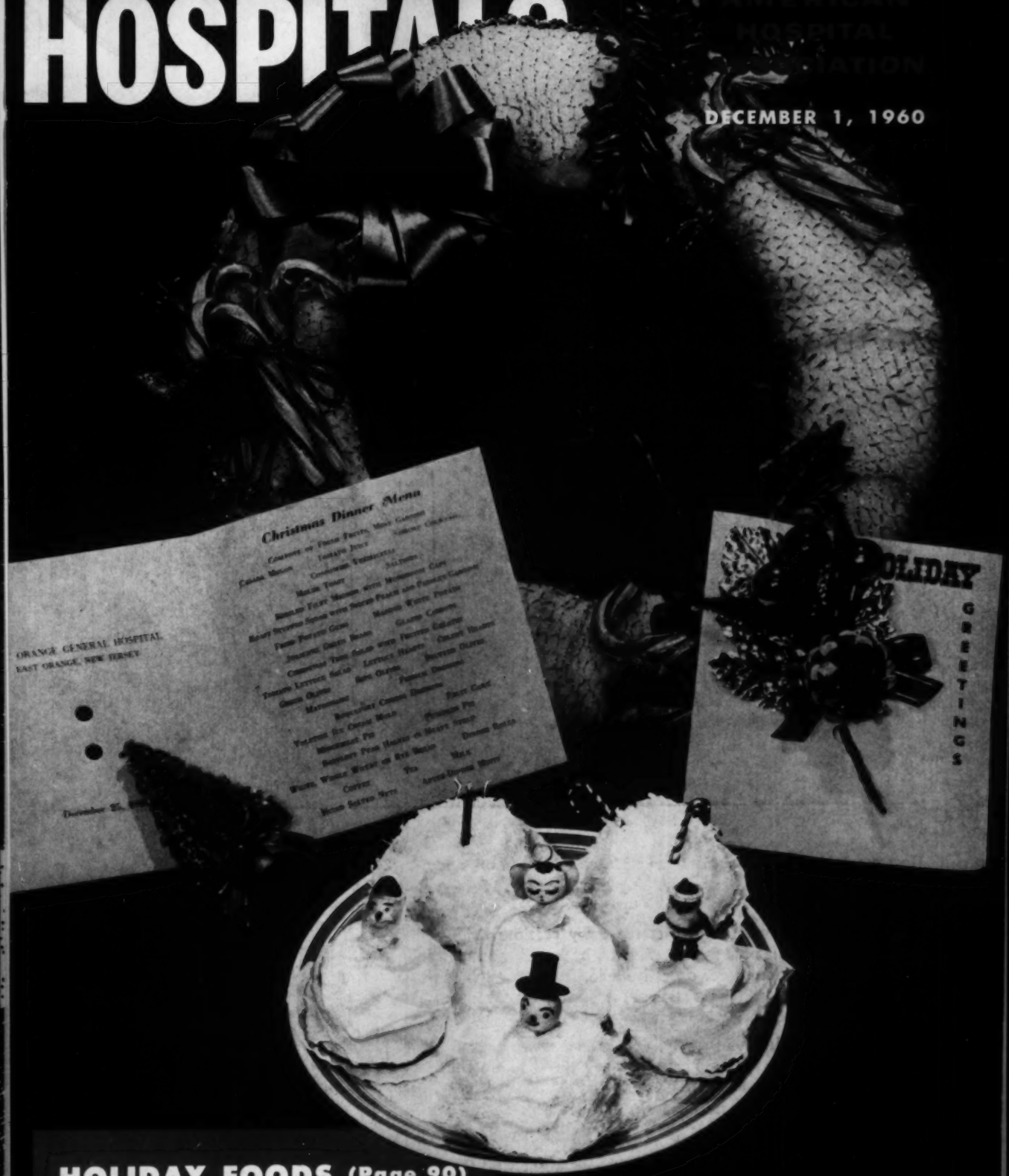
HOSPITALS

JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

DECEMBER 1, 1960



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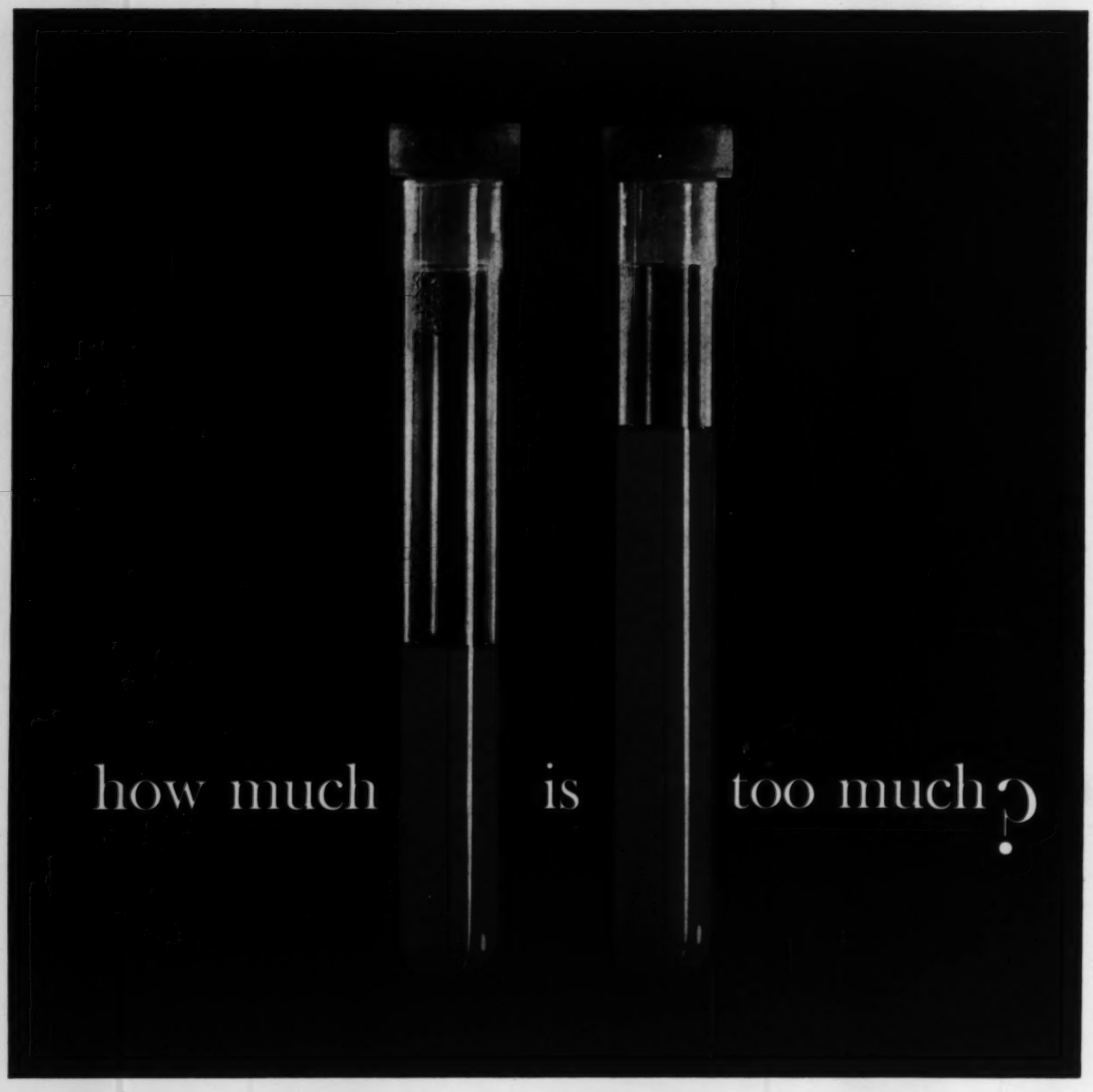

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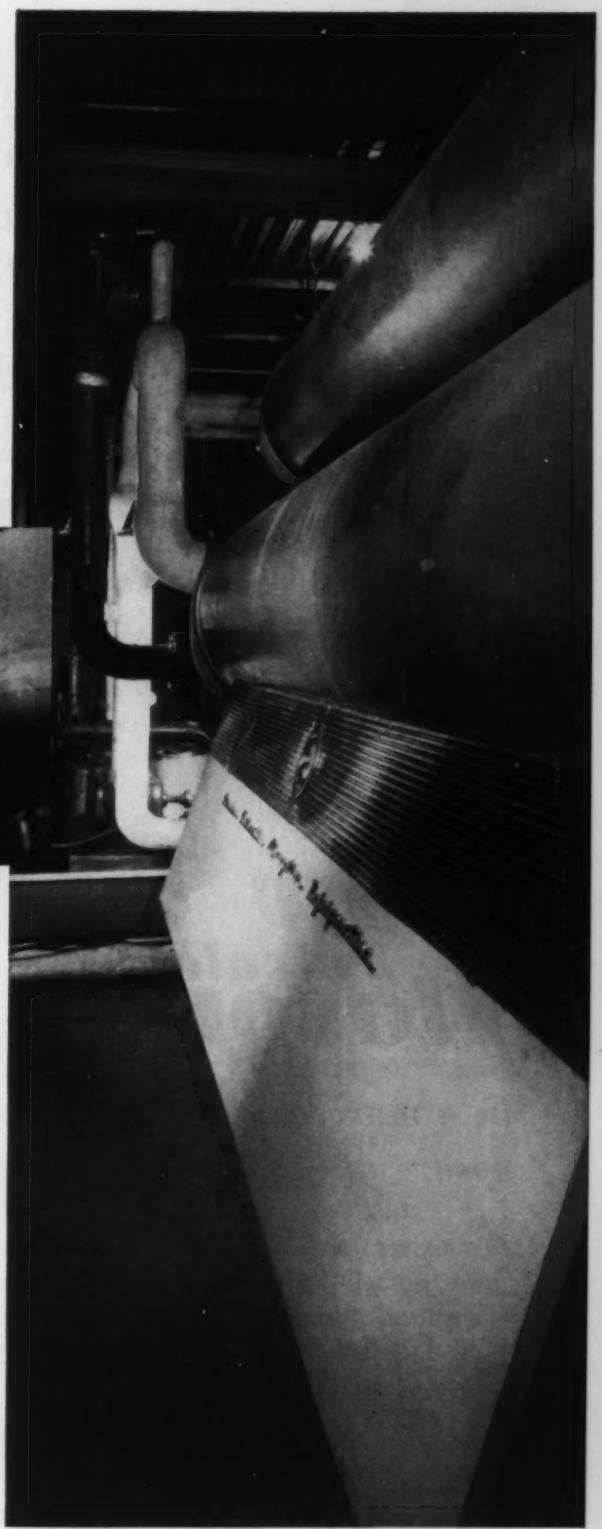

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1. Stephens, V. C., *et al.*: J. Am. Pharm. A. (Scient. Ed.), *48*:620, 1959.
2. Salitsky, S., *et al.*: Antibiotics Annual, p. 893, 1959-1960.
3. Reichelderfer, T. E., *et al.*: Antibiotics Annual, p. 899, 1959-1960.
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cover

Festive holiday foods, specially printed holiday menus and attractive tray favors can help to make the hospital more like home for patients during the holiday season. Twenty-six recipe and menu suggestions for holiday foods begin on page 90. Cover photo courtesy of East Orange (N.J.) General Hospital. (Other picture credits on page 122.)

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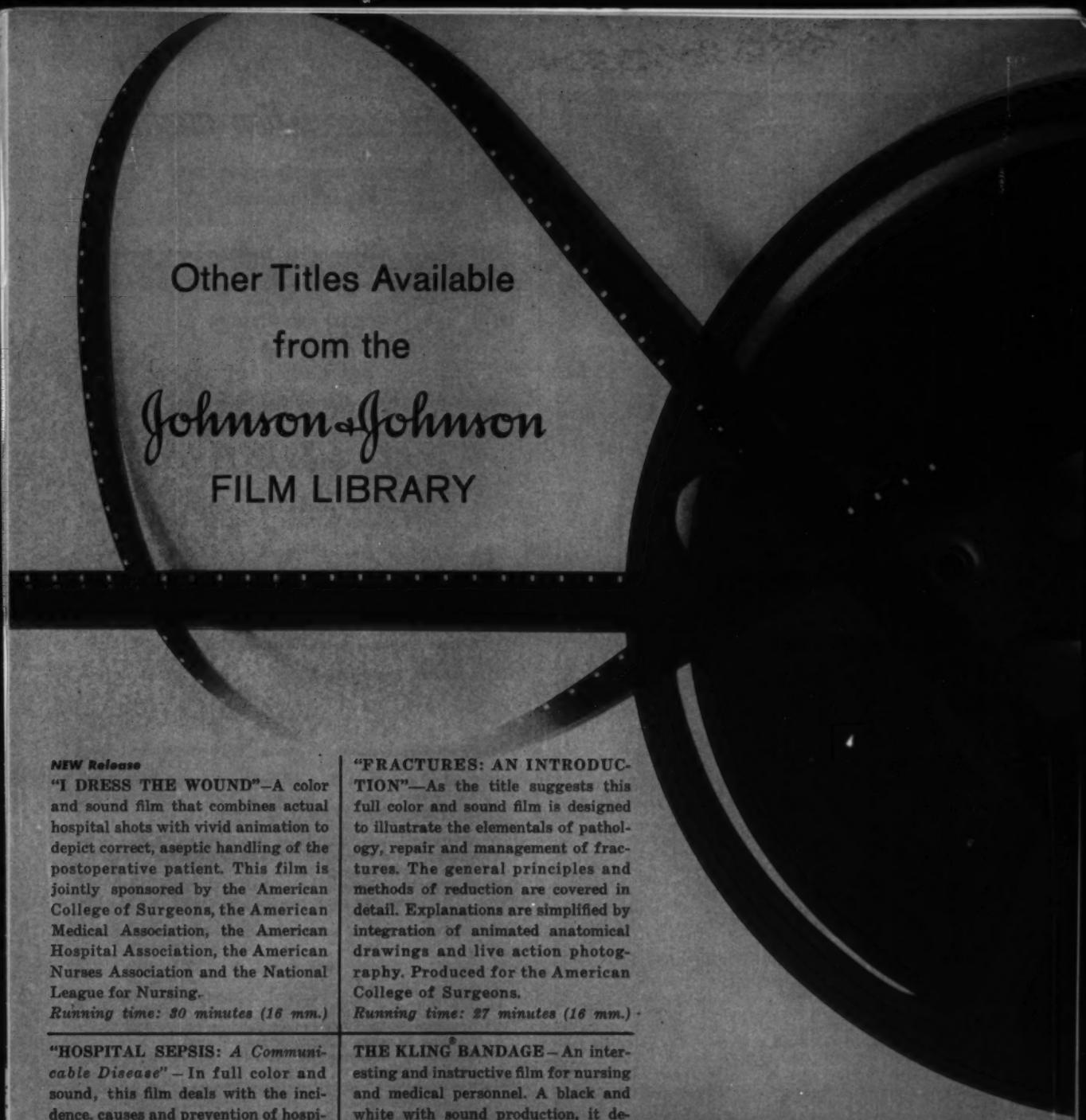

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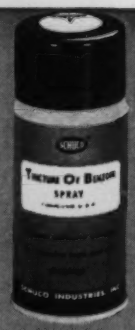

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AMERICAN HOSPITAL ASSOCIATION

NATIONAL MEETINGS

1961

Feb. 1-2—**Midyear Conference of Presidents and Secretaries,** Chicago (AHA Headquarters)
Sept. 25-28—**63rd Annual Meeting,** Atlantic City (Convention Hall)

MEETING AND INSTITUTE CALENDAR

THROUGH MAY 1961

(American Hospital Association Institutes are in BOLDFACE type. Meetings of other hospital associations are in LIGHTFACE type. *Other organizations in the health field are shown in ITALICS.)*

DECEMBER

1-2 Florida Hospital Association, Miami (Everglades Hotel)
1-2 Illinois Hospital Association, Chicago (Pick-Congress Hotel)
4-9 *Radiological Society of North America,* Cincinnati (Netherland-Hilton Hotel)
5-7 **Hospital Purchasing (Advanced),** San Francisco (Bellevue Hotel)
5-7 **Medical Record Librarians (Advanced),** Chicago (AHA Headquarters)
5-8 **Nursing Service Supervision,** Roanoke (Hotel Roanoke)
12-14 **Labor Relations,** Chicago (AHA Headquarters)
12-15 **Hospital Design and Construction,** Washington, D.C. (Park-Sheraton)
26-31 *American Association for the Advancement of Science,* Philadelphia

JANUARY

8 Puerto Rico Hospital Association, Santurce (Medical Association Bldg.)
16-19 **Evening and Night Nursing Service Administration,** Tulsa, Okla. (Mayo Hotel)
16-20 **Nurse Anesthetists,** St. Louis (Coronado Hotel)
18-20 **Labor Relations,** Boston (Somerset Hotel)
19-20 Alabama Hospital Association, Montgomery (Whitley Hotel)
23-24 *National Association of Private Psychiatric Hospitals,* Scottsdale, Ariz. (Safari Hotel)
23-27 **Hospital Purchasing,** Minneapolis (Pick-Nicollet Hotel)
30-Feb. 3 American Protestant Hospital Association, Kansas City (Muehlebach Hotel)
30-Feb. 3 **Central Service Administration,** Boston (Somerset Hotel)

FEBRUARY

2-4 *American College of Hospital Administrators,* Fourth Annual Congress on Administration, Chicago (Morrison Hotel)
4-7 *American Medical Association,* Congress on Medical Education and Licensure, Chicago (Palmer House)
8-10 **Community Relations for Hospital Auxiliaries,** Chicago (AHA Headquarters)
13-16 *Association of Operating Room Nurses,* San Francisco (Whitcomb Hotel)
13-17 **Dietary Department Administration,** Oklahoma City (Oklahoma-Biltmore Hotel)
23-25 Louisiana Hospital Association, Shreveport (Captain Shreve Hotel)
27-Mar. 1 **Management Development,** Chicago (AHA Headquarters)
27-Mar. 3 **Nursing Service Administration,** Houston, Tex. (Rice Hotel)

MARCH

3-16 *National Health Council,* National Health Forum, New York City (Waldorf-Astoria)
6-8 **Hospital Law,** Austin, Tex. (Commodore Perry Hotel)
6-10 **Hospital Purchasing,** Pittsburgh (Penn-Sheraton Hotel)
16 Wisconsin Hospital Association, Milwaukee (Schroeder Hotel)
20-22 **Personnel Administration (Basic),** Chicago (AHA Headquarters)

(Continued on page 118)

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IN BRIEF

Terramycin Intramuscular Solution, a *preconstituted* parenteral form of oxytetracycline with 2% Xylocaine* as a local anesthetic, facilitates prompt initiation of broad-spectrum antibiotic therapy when immediate oral administration is inconvenient or impractical. There is a low incidence of irritation or pain at the injection site. Availability of the *new*, multi-dose 10 cc. vial permits greater *economy*, *convenience*, and *flexibility* in dosage. The dependability of Terramycin is based on broad antimicrobial effectiveness, excellent toleration, and low order of toxicity.

INDICATIONS: All oxytetracycline indications whenever initial or continuing therapy with I.M. injection is indicated. Compatible oral therapy may then be given with Cosa-Terramycin® Capsules or Cosa-Terrabon® Suspension. Effective against both gram-positive and gram-negative bacteria, rickettsiae, spirochetes, and large viruses, Terramycin therapy is indicated in a great variety of infections due to susceptible organisms. These include infections of the respiratory tract, ophthalmic and otic infections, gastrointestinal infections, genitourinary infections, soft-tissue infections, and many others.

ADMINISTRATION AND DOSAGE: For intramuscular injection only. Unless otherwise specified, a dose of 100 mg. every 8-12 hours, or a single daily dose of 250 mg. should be adequate for most mild or moderately severe infections. In *severe* infections, 100 mg. every 6-8 hours or 250 mg. every 12 hours may be necessary. Dosage for infants and children is proportionately less and should be determined in accordance with age and weight of the patient, and severity of infection.

SIDE EFFECTS AND PRECAUTIONS: Aside from occasional mild pain at injection site, adverse reactions (including allergic) have been rare. As with all I.M. preparations, injection should be made within the body of a relatively large muscle. After insertion of needle, aspiration should be attempted before injecting to avoid inadvertent administration into a blood vessel; care should always be taken to avoid injecting into a major nerve or its surrounding sheath. Subcutaneous and fat-layer injection may cause mild pain and induration, which may be relieved by an ice pack.

Use of antibiotics may result in an overgrowth of nonsusceptible organisms—particularly monilia and resistant staphylococci. If a new infection caused by a resistant pathogen appears, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing.

SUPPLIED: *Terramycin Intramuscular Solution* is available in the new 10 cc. multi-dose vial, providing five 2 cc. doses, 50 mg./cc., and in 2 cc. prescored glass ampules, containing 100 mg. and 250 mg., packages of 5 and 100. For maximum rapidity of effect—*Terramycin Intravenous*, in vials of 250 mg. and 500 mg. (buffered with 1 Gm. and 2 Gm. ascorbic acid, respectively). Available for oral therapy: *Cosa-Terramycin® Capsules*, 250 mg. and 125 mg.; *Cosa-Terrabon® Oral Suspension* (preconstituted), 125 mg. per 5 cc. teaspoonful, in bottles of 2 oz. (60 cc.) and 1 pint; *Cosa-Terrabon® Pediatric Drops* (preconstituted), 5 mg. per drop (100 mg. per cc.), bottle of 10 cc. with calibrated plastic dropper. In addition, a variety of other systemic and local dosage forms are available to meet specific therapeutic requirements.

More detailed professional information available on request.

*Xylocaine® is the trademark of Astra Pharmaceutical Products, Inc. for its brand of lidocaine.

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Three major criteria for an effective laxative have been established by physicians*

1. freedom from griping or other irritating side effects

2. clinically proven effectiveness

3. predictable action

*Results of a survey of over 1,000 physicians conducted by the Bureau of Research, Inc., 555 W. Jackson Blvd., Chicago 6, Illinois (April, 1960).

PERI-COLACE®

Anthraquinone derivatives from cascara and dioctyl sodium sulfosuccinate, Mead Johnson

meets physicians' criteria for an effective laxative

With Peri-Colace "...side effects such as griping are reduced to a minimum."[1]

Peri-Colace, a unique combination of Peristim® and Colace® (dioctyl sodium sulfosuccinate) "...gave satisfactory results in 97 per cent of the cases [130 hospitalized patients]."[2]

Experience in practice has shown the unusual dependability of Peri-Colace.[1-4] It promptly, yet gently, induces bowel evacuation within 8 to 12 hours in most patients.

References: (1) Broders, A. C., Jr.: Am. J. Digest. Dis. *2*:483-486 (Sept.) 1957. (2) Lamphier, T. A.: Am. J. Proctol. *8*:442-444 (Dec.) 1957. (3) Smigel, J. O.; Lowe, K. J.; Hosp, P. H., and Gibson, J. H.: M. Times *86*:1521-1526 (Dec.) 1958. (4) Turell, R.: Curr. M. Dig. *26*:61-69 (Feb.) 1959.

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Symbol of service in medicine

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introducing the authors

Robert V. Fay, administrator of Community Memorial Hospital, Ayer, Mass., describes the advantages of a recovery table in his article on page 45.

MR. FAY

Prior to assuming his present position in 1956, Mr. Fay served as assistant administrator of the Bridgeport (Conn.) Hospital for seven years. He also completed his administrative residency at the hospital following completion of the academic requirements for a master's degree in hospital administration at Northwestern University.

Mr. Fay has served on various committees of the Connecticut and Massachusetts hospital associations and was secretary of the Hospital Administrators' Club of the Worcester (Mass.) Area. He is also a past regional director of the Northwestern University Hospital Administration Alumni Association.

He is a fellow of the American College of Hospital Administrators.

Russell F. Lovell, chief pharmacist at the Akron (Ohio) City Hospital, outlines some of the achievements of the hospital's pharmacy and therapeutics committee (p. 71).

MR. LOVELL

Mr. Lovell has been associated with the Akron hospital since 1947. He is also an instructor in pharmacology at the hospital's school of nursing. He currently serves as secretary of the pharmacy committee of the hospital's medical staff as well as a member of the hospital's infections and disaster committees.

Mr. Lovell is a life member of the American Pharmaceutical Association and a member of the American Society of Hospital Pharmacists. He is also a member of the Ohio and Summit County pharmaceutical associations. Mr. Lovell has served for six years as chairman of the Akron (Ohio) Area Student Visit Project, a hospital pharmacist recruitment program.

Mr. Lovell received his bachelor of science degree in pharmacy at Ohio State University, Columbus.

James R. McCarroll, M.D., and Paul A. Skudder, M.D., report the results of a nation-wide survey of hospital emergency departments in their article beginning on page 34. Drs. McCarroll and Skudder are both associated with the New York Hospital-Cornell Medical Center, New York.

DR. McCARROLL

DR. SKUDDER

Dr. McCarroll, director of epidemiologic research at Cornell University Medical College for the past three years, became interested in the problems of trauma and emergency care through the Cornell studies on automotive crash injury, which he formerly headed.

After graduating from Cornell University Medical College in 1946 and upon completing his residency training in internal medicine at Bellevue Hospital Center, New York, Dr. McCarroll returned to

(Continued on page 119)

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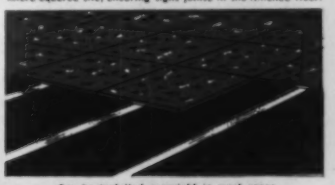

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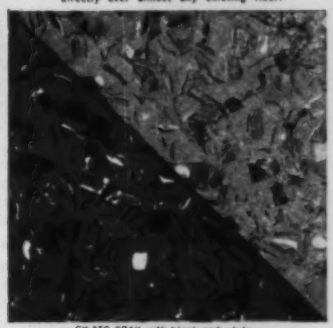

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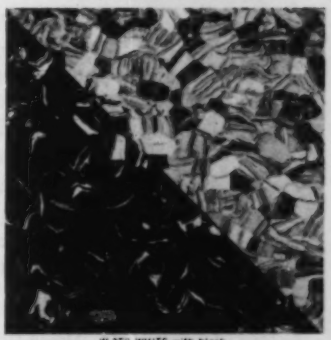

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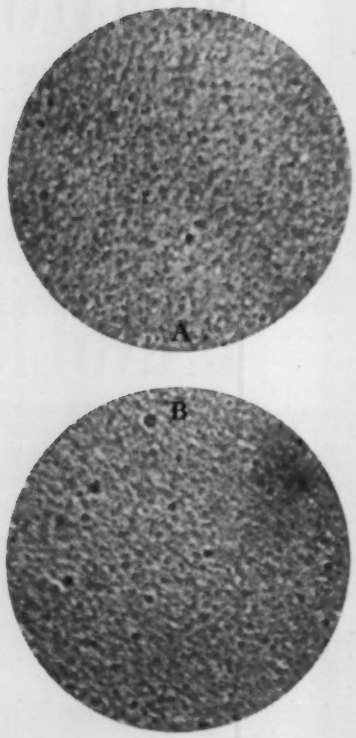

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As you know, after digestion, fat passes as an emulsion called chyle through the lacteals into the lymphatics tributary to the thoracic duct, and then into the systemic circulation. Lipomul I.V., like chyle, is a *fine milk-white emulsion of fat.* Its fat particles approximate those of chyle in size: about *1/7 the diameter of the normal red blood cell.* Because of this minute particle size, like chyle, Lipomul I.V. is *non-irritating to the vein.* The fat provides *8 times more protein-sparing calories* per cc. than does 5% glucose. It is *swiftly* and *completely metabolized.* **Therefore,** when formation of chyle, a major source of calories, is blocked during pre- and post-operative "digestive tract bypass", many surgeons add Lipomul I.V. to their standard fluid and electrolyte regimen to provide the most concentrated source of energy.

†**A**—Mammalian chyle (magnified 2500X)
B—Lipomul I.V. (magnified 2500X)

Formula:

Cottonseed Oil	15% w/v
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Lecithin	1.2% w/v
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Supplied in 250 cc. and 500 cc. bottles

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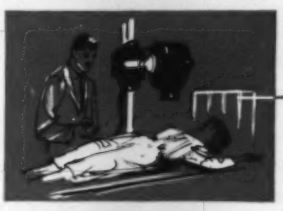
Picker Minograph photofluorographic miniature film units in a variety of models for efficient handling of any caseload.



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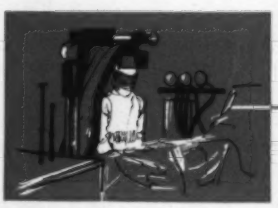

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"Roving" Picker x-ray units to serve any room in the O.R. Suite. Or built-in overhead x-ray combined with effective surgical lighting (all explosion-safe and Underwriter-Listed).

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Radiation-measuring instrumentation for thyroid uptake, kidney function and similar tests. Labeled radioactive compounds. Detectors, scalers, ratemeters, counters, for the gamut of research and clinical applications.

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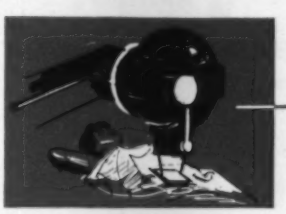
Full range of Picker apparatus for superficial, intermediate, and deep x-ray therapy. All necessary positioning and protective accessories, including room-shielding.



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Picker Cobalt^{60} teletherapy units for rotational and fixed beam technics. Four different types, with outputs from 2,000 to 10,000 rhm. Ceiling-mounted Cesium^{137} units.

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X-ray, darkroom, therapy, and radioisotope department planning at any level from preliminary rough-ups to finished layouts with full specs. Your local Picker man (a trained expert in his own right) is always at your beck and call.

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Thousands of hospitalmen do just that, year after year, on the basis of *proven* advantage. Picker X-Ray sales offices and service depots (always on their toes to serve you) are strategically spotted in principal cities the country over. See your local 'phone book or write Picker X-Ray Corporation, 25 South Broadway, White Plains, New York.

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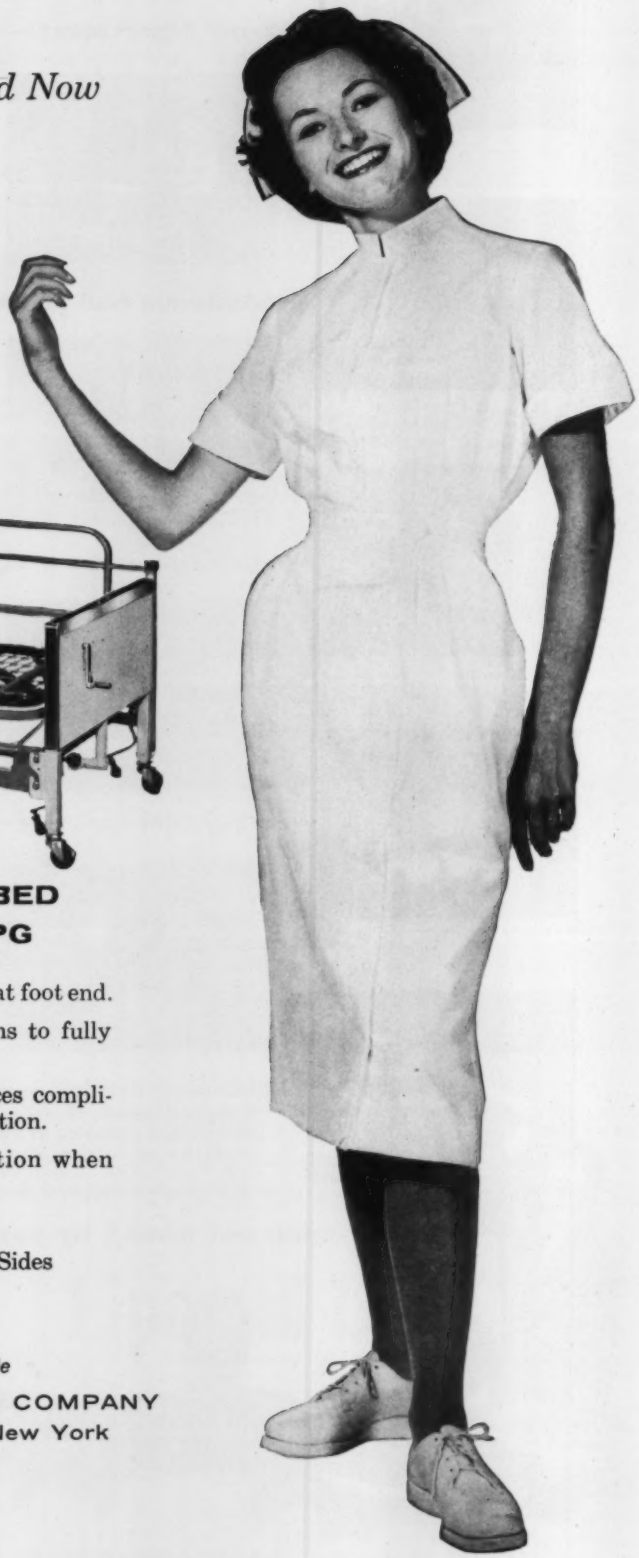

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FCC RULING GIVES RADIO FREQUENCIES TO HOSPITALS—The Federal Communications Commission (FCC) has announced new rules to include hospitals and ambulances in the Special Emergency Radio Service. The ruling, which is effective December 1, sets aside five radio channels in the 150 megacycle band for the exclusive use of hospitals and their mobile units.

The Commission also expanded radio communications to include urban as well as rural physicians. The ruling authorizes hospital radio use in day-to-day activities and in the time of disaster, for the "transmission of messages necessary for the rendition of an effective hospital service."

The FCC's ruling represents the achievement of an objective sought for the last three years by the American Hospital Association to obtain eligibility standards and reserved frequencies to meet the radio needs of hospitals. *(Details p. 113)*

CONTROVERSY IN BUFFALO OVER PROPOSED BLUE CROSS-BLUE SHIELD RATE INCREASE—A proposal to increase premium rates for Blue Cross and Blue Shield prepaid insurance in Buffalo was the subject of controversy at a public hearing conducted by the State Department of Insurance.

The Western New York Medical Plan, which provides Blue Shield insurance in this area, has applied for an average premium rate increase of 36.05 per cent. The Hospital Service Corporation of Western New York (Blue Cross) has asked for authority to raise subscriber rates an average of 23.66 per cent.

Joseph M. Kerrigan, executive vice president of the Blue Shield Plan, said the rate increase was due to the inability to predict the utilization and consequent costs of the service-type contracts that were provided for the first time four years ago. He said that income was running $793,811 behind expenditures.

Carl M. Metzger, president of the Blue Cross Plan, said that the increases were necessary to meet payment to hospitals based on "identifiable trends, plus cost factors which hospital administrators advise us must be recognized for the next two years."

Among those opposing the rate increase was Joseph P. Molony, district director of the United Steelworkers of America. He warned that if the increase was granted his union would have "no choice but to seriously seek new methods of providing good, effective, modern, reasonably priced and fully prepaid medical care for their families."

Harold A. Mercer, assistant secretary and director of industrial relations for the Pittsburgh Metallurgical Co., Niagara Falls, stated that industry would be unable to continue paying "fringe benefits" such as Blue Cross and Blue Shield if the increase went through.

MILWAUKEE ADOPTS PROGRAM TO CONSERVE HOSPITAL RESOURCES—A program to conserve hospital and medical resources in the Milwaukee area has grown out of a three-month intensive study of the use of hospital facilities and medical resources by 21 hospitals. The program is sponsored jointly by the Medical Society of Milwaukee County, the Milwaukee hospitals, Blue Cross and Surgical Care Blue Shield.

Five major recommendations included in the program are: (1) the creation of a hospital utilization program to make recommendations on the use of hospital facilities; (2) the review by a Blue Cross-Blue Shield conference committee of utilization reports; (3) the establishment of an educational program for physicians on the conservation of resources; (4) the expansion of Surgical Care Blue Shield contracts in the scope of services, and (5) the establishment of a public educational program regarding proper use of hospital facilities. The five-point program is designed to be preventive rather than remedial. *(Details p. 115)*

NEW YORK GOVERNOR REQUESTS HOSPITAL INFORMATION SYSTEM—Gov. Nelson A. Rockefeller of New York has requested the State Hospital Planning and Review Council to work with voluntary and local public organizations in establishing a state-wide system for gathering information on utilization, suitability and services of hospitals.

The council will work with the New York Department of Social Welfare and use information obtained by the department through its hospital reporting system.

As another phase of this expanded program, the State Hospital Planning and Review Council was authorized by the governor to study and recommend standards for prepayment health insurance plans.

REPORT FROM WASHINGTON—Post-election speculation ran high on the prospects for Congressional action on the legislative program pledged by President-elect Kennedy in his campaign. It appeared that there would be no quick Congressional approval of Mr. Kennedy's proposals, but on the other hand the White House veto which has faced recent Democratic Congresses was gone.

The six-point "New Frontiers of

Worth Quoting

"If Americans each set aside $100 a year for sickness insurance, we should have $16 billion (or $18 billion if we use 1960 census figures), for education, research, medical care, and the very preventive measures that would reduce the need for medical care."—Alan Gregg, M.D., in *Challenges to Contemporary Medicine* (1956).

Health" program which was proposed during the campaign by Mr. Kennedy, specified care for the aged; federal grants for medical, dental and public health schools; loans and scholarships; grants for hospital renovations; grants for medical research, and expanded physical rehabilitation programs. • It was the opinion of many health experts prior to the election that, regardless of which candidate won, the program for the care of medically indigent aged which was enacted by Congress last August would not only continue, but also serve as a base for future expanded programs. It appeared that so far this opinion was being upheld. *(Details p. 103)*

NEW YORK LABOR GROUP PLANS UNITED EFFORT TO KEEP MEDICAL COSTS DOWN—An effort to unite labor unions, employers, the medical profession and hospital administrators in keeping down the cost of medical care has been undertaken by the Central Labor Council in New York City, a coordinating body for all affiliates of the AFL-CIO. The council has set up a Professional Advisory Committee, consisting of leaders in the medical societies, Blue Cross, public and private hospitals and other agencies in the health field.

The project is designed to solve the problem of medical and hospital costs for the one million members of unions in New York City. The unions seek a guarantee of maximum protection from their employer-financed welfare plans, it was reported.

HALF OF MICHIGAN'S NURSING HOME PATIENTS SUPPORTED BY PUBLIC—Findings of a state-wide survey of Michigan's 547 accredited nursing homes showed that large majority of patients could not be cared for at home, that the percentage of sick and incapacitated has been rising steadily over the years and that 50 per cent of them are supported entirely at public expense.

The survey, made by the University of Michigan School of Public Health under the direction of Kenton E. Winter Jr., research associate in the Bureau of Public Health Economics, found that only 24 per cent of the patients had been admitted directly from general hospitals. It was pointed out that this figure indicates that a nursing home is not viewed as a place providing post-hospital convalescent care nor as a place to which hospital patients needing continuing nursing care are referred at the point of discharge.

The results of the survey contradicted the belief that aged patients are usually sent to nursing homes because their families lack interest. More than 90 per cent of the patients had at least one disease, and the majority could not be cared for at home.

It was found that privately operated nursing homes are more numerous, but county facilities are larger in size and handle nearly one-third of all patients.

The survey showed a wide variation in the cost of care. The average figure was $165 per month, with half the patients supported entirely by public funds and only one-third supported entirely by private sources.

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MANUAL CONTROL—Permits intermittent positive pressure administration of oxygen.

UNIQUE DESIGN—Provides for endotracheal intubation during prolonged ventilation of infants with asphyxia.

TEMPERATURE MAINTENANCE—Explosion-proof electric heater accurately maintains desired temperature.

EASY DRAINAGE—Infant's head easily positioned to place trachea in line with pharynx and mouth.

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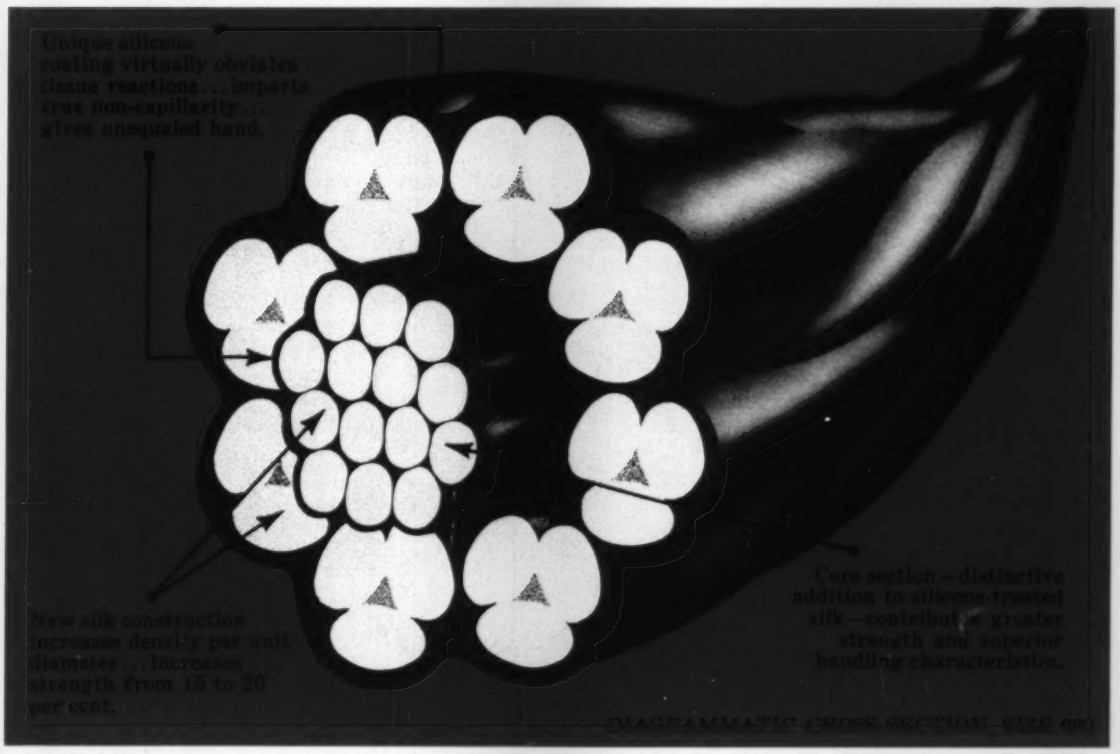
Unique silicone coating virtually obviates tissue reactions... imparts true non-capillarity... gives unequaled hand.
New silk construction increases density per unit diameter... increases strength from 15 to 20 per cent.
Core section—distinctive addition to silicone-treated silk—contributes greater strength and superior handling characteristics.

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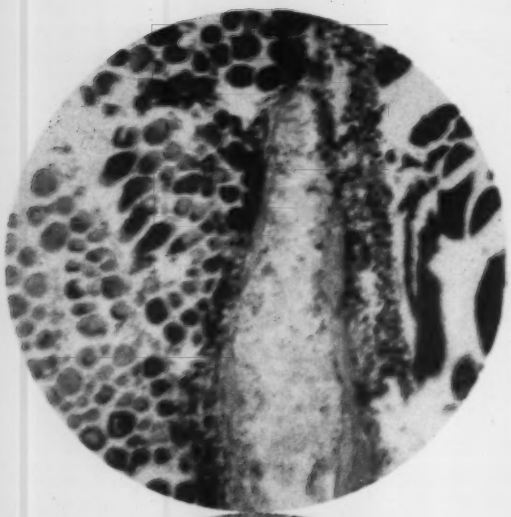

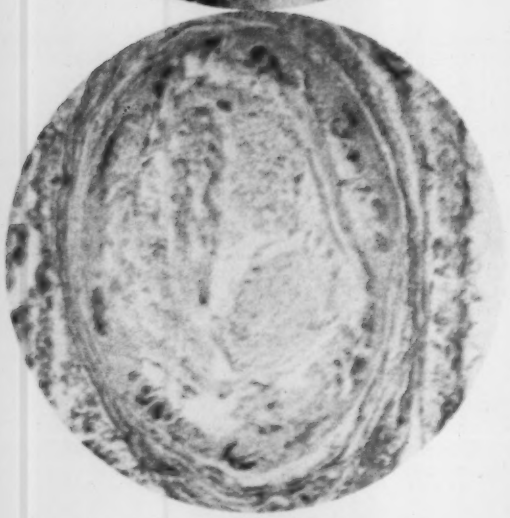

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New silicone-rubber coating dramatically overcomes the problem of tissue reactions reported[1-4] with wax-coated silk.

No granuloma, paraffinoma, adhesions, inflammatory reaction or other significant adverse response has been encountered with the surgical use of silicone material.[5-10] Excellent tissue tolerance shortens "lag period," does not inhibit tissue repair. The unique coating process encases all fibers of the suture strand in pure, surgical silicone rubber to present a continuum of physiologically inert suture material to the tissues.

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40-day embedment: Thin dense sclero-collagen capsule surrounds suture. No other remarkable findings. No increase in suture volume. (Section cut obliquely to long axis, giving elongation.)

COMMON REACTION TO WAX-COATED SILK

40-day embedment: Moderately thickened sclero-collagen capsule surrounds suture mass. Granulation tissue invaded and increased suture mass by about a factor of 4 over that observed after three days. Many foreign body giant cells on inside of collagen capsule. New blood vessel elements on the border of the capsule.

Mallory's connective tissue stain. Sections cut at 7 microns. Photomicrographs taken at 100x. Suture size: 00

References:

1. Wilkinson, J. F.; Freeman, G. G.; New, N., and Noan, R. D.: Lancet 271:621, 1956. 2. Brown, J. B.; Fryer, M. P., and Lu, M.: A.M.A. Arch Surg. 68:744, 1954. 3. Large, O. P.: Am. J. Surg. 60:415, 1943. 4. Wolf, R.: Ibid. 55:153, 1942. 5. Rosenberg, N.; Moolten, S. E., and Vroman, L.: Arch Surg. 60:363, 1950. 6. Blunt, Jr., W. J.: Am. J. Surg. 95:512, 1958. 7. Lahey, F.: New England J. Med. 240:161, 1949. 8. Dimant, S.: Lancet 267: 533, 1954. 9. Rowe, V. K.; Spencer, H. G., and Bass, S. L.: J. Ind. Hygiene & Toxicol. 30:332, 1948. 10. DeNicola, R. R.: J. Urology 63:168, 1950.

SILICONE-TREATED SILK SUTURES

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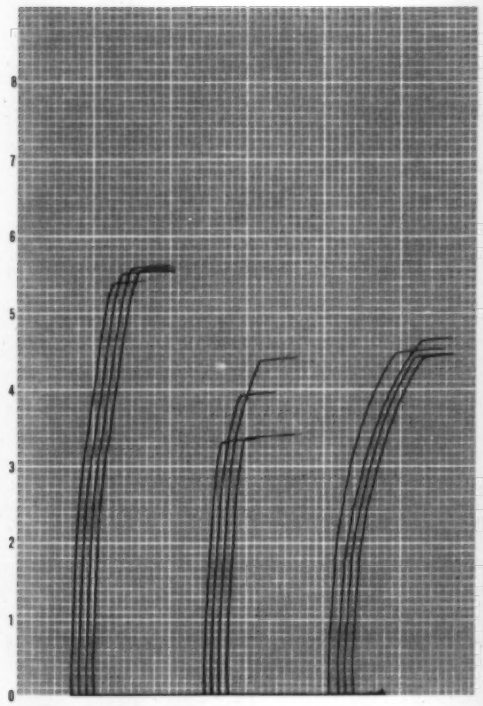

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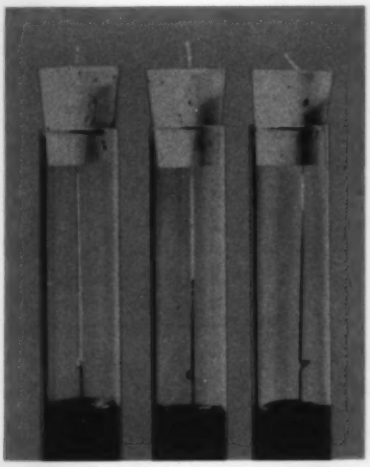
Superiority over other silks is achieved through new, unique braiding process which increases silk density per unit diameter. Added strength may permit selection of smaller size suture in some instances. Silicone coating prolongs *in situ* strength, protects suture against enzymatic or body fluid invasion. Continued tissue-approximation is assured; neo-vascularization and fibrosis are minimized.



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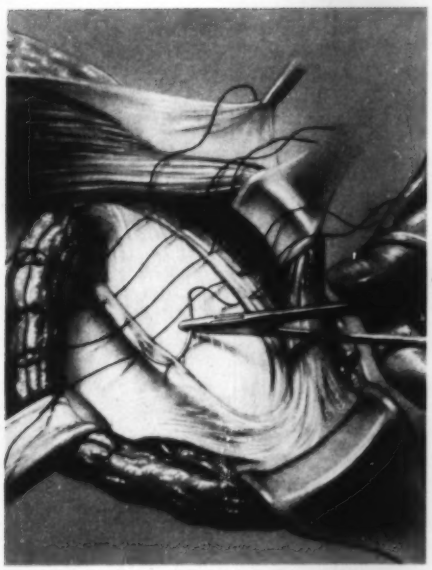

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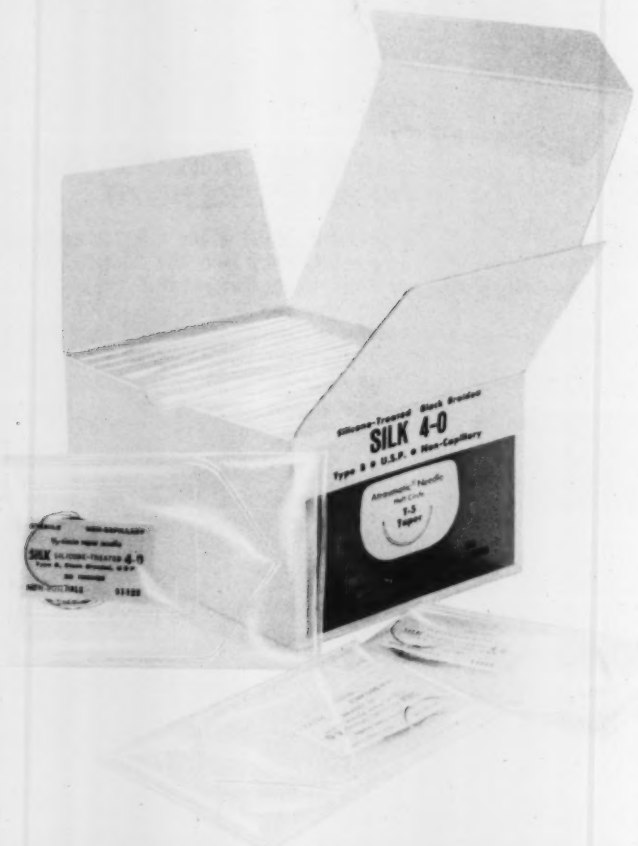

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Volunteer director salary

In hospitals having a paid director of volunteer services, who ordinarily pays the salary, the hospital or hospital auxiliary?

When a hospital has a director of volunteers on a salaried basis, this salary should be paid by the hospital, just as in the case of any other employee of the hospital—department head or otherwise. In this manner, all employees are assured of such benefits as social security, sick leave and vacation and many other specific "fringe" benefits.

In some hospitals, the auxiliary arranges to supply the funds to cover the salary of the director of volunteers—sometimes for a period of the first year of the program and sometimes for a longer period. However, in all cases, the funds should be given to the hospital so that it actually pays the salary. The auxiliary might, in such a case, make a contribution to the hospital in the amount of the annual salary for the director of volunteers, or it might budget a certain amount to be given monthly toward the salary.

No matter who pays the salary for the director of volunteers, there should not be any problem concerning the responsibility of the director of volunteers. This department head is a member of the hospital staff, and is directly responsible to administration.

—MRS. GERMAINE FEBROW

Isolation rooms

What would be an effective yet practical isolation procedure for a 50-bed hospital? Should we set aside a room or two specifically for isolation or could any private room be used if proper techniques are followed?

It is acceptable procedure to care for patients on isolation in private rooms. Terminal disinfection of floors, furniture, and bedding assures safety of the use of the room for new admissions. Since it is usually impossible to predict with accuracy the number of isolation beds required at any one time, it is more economical to plan to use available private rooms. The private room should have an adjoining lavatory with running water and toilet facilities. If the use of semiprivate facilities is contemplated, glass cubicles and ultra-violet curtains are recommended.—ELEANOR C. LAMBERTSEN

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

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opinions and ideas

LETTERS TO THE EDITOR

Suspension of medical staff

(The following letter was sent to Mrs. Luella T. Penner, registered record librarian, and to T. E. Besser, administrator, both of the Hudson (Wis.) Memorial Hospital, following publication of Mrs. Penner's article on medical record problems in the smaller hospital in the September 1 issue of the Journal.)

Dear Mrs. Penner

Since I have been concerned for more than 30 years with the problem of adequate medical records, both in meeting the former standards of the American College of Surgeons and in meeting the present standards of the Joint Commission on Accreditation of Hospitals, I was very much interested in your article on medical records beginning on page 48 of the September 1 issue of this Journal. I feel so strongly about certain things in the article that I want to make these comments to you and to your administrator.

In Figures 1 and 2, page 50, I was surprised to find that the memorandum suspending a medical staff member was signed by the president of the hospital's medical staff. The statement that they are to be so signed, after approval has been given by the administrator, appears in the next to the last paragraph of the first column, page 52.

Legally, the president of the medical staff has no authority to suspend a staff member. This can only be done by, or authorized by, action from the hospital's board of trustees and should, of course, be transmitted to the offending staff member through the board's legal representative—the hospital administrator. Having such a notice signed by the medical staff president belittles the position of the administrator and tends to submerge his authority.

I believe very strongly, and I am sure that a vast majority of hospital administrators and other authorities in our field would agree that such notices definitely should be signed by the hospital administrator and that the notice should contain a statement indicating clearly that the action taken is the result of rules and regulations recommended by the medical staff and approved as hospital policy by the board of trustees.

Your statement that "the automatic suspension was not so automatic because the president of the staff was not, at the time of the amendments, in favor of the suspension program," itself indicates how out of place it is to have the president of the medical staff sign the suspension notice.

This is a vitally important organizational and operational problem and I sincerely hope that the editors of **HOSPITALS**, J.A.H.A., will make note of this in a subsequent issue.—EVERETT W. JONES, *consultant, Fort Myers Beach, Fla.*

Mr. Besser and Mrs. Penner replied to Mr. Jones' letter as follows:

It was decided that the president of the medical staff should sign the suspension notice after approval by the administrator because we believed that the medical staff should be self-governing and, therefore, it should also be self-disciplining. As administrator of the hospital, I am consulted prior to the suspension, since I originally sign the pending notice of suspension. Actually, the president of the medical staff has been given full authority by both the medical staff and the board of directors to sign the suspension notice.

We have not included the complete rules and regulations of the medical staff on the notice of suspension because we are a smaller hospital and all of the physicians have complete copies of the by-laws, rules and regulations (including the amendments).

I do not believe that my position as administrator is being belittled or that my authority is being submerged. I worked for months to get this procedure adopted.—T. E. BESSER, *administrator, Hudson (Wis.) Memorial Hospital.*

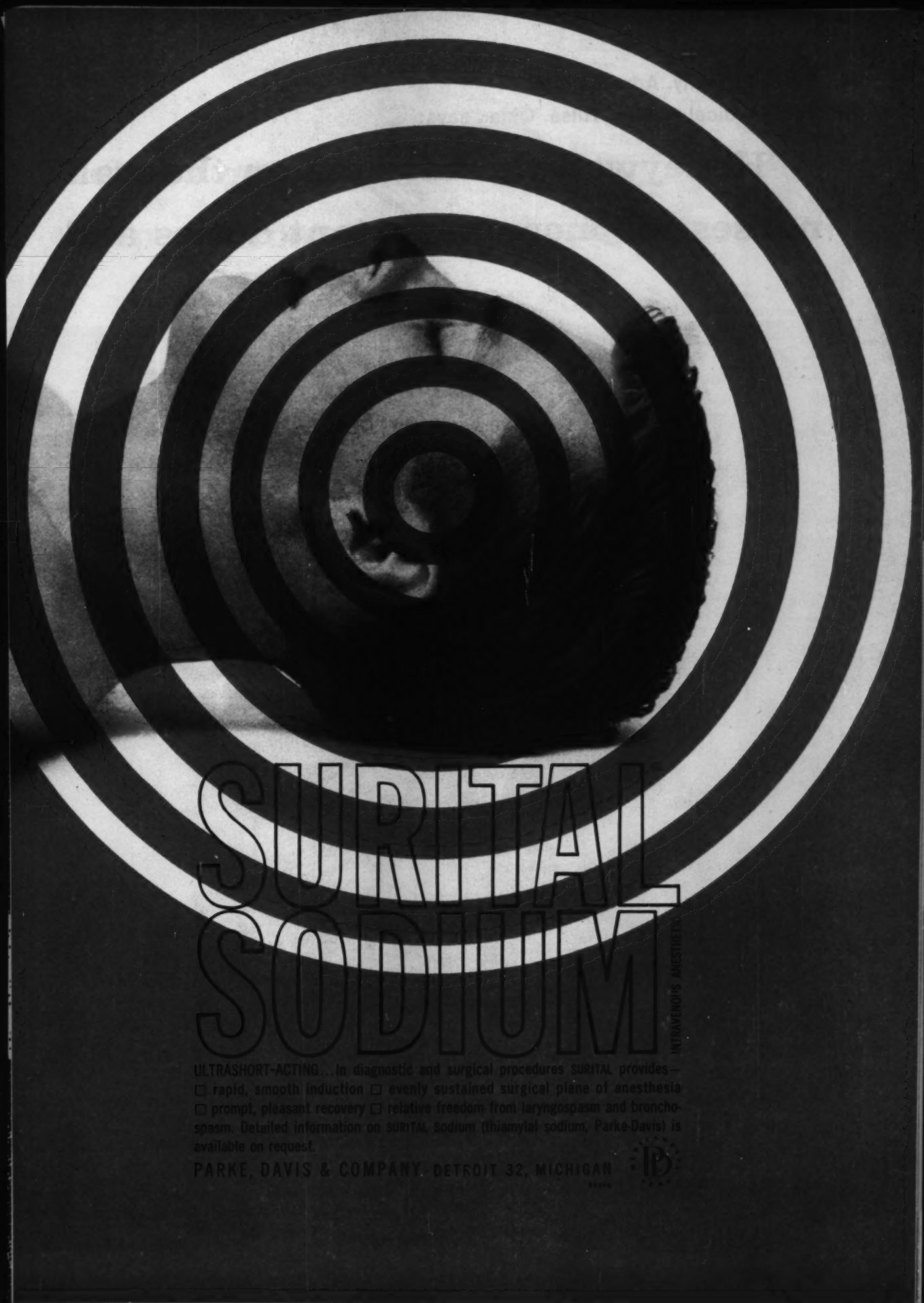
In the Standards set by the Joint Commission on Accreditation of Hospitals, we find that the medical staff responsibilities include "support of medical staff and hospital policies and maintenance of adequate medical records." I believe that "support of . . . policies" can be interpreted as adherence to whatever policies are established. Certainly, the method of suspension of medical staff members which we have devised—be it the president of the medical staff or the administrator of the hospital that signs the suspension slip—is a matter of individual medical staff and hospital policy. And certainly, if better medical records can be maintained because the medical staff president signs the suspension slips, we are all in favor of it!

At Hudson Memorial Hospital, we believe that disciplinary action should be carried out by the medical staff. If this is not properly done, or to the satisfaction of the governing board, then the governing board should take action. In the medical records section of the June 1956 issue of *Hospital Management*, Edna K. Huffman, C.R.L., stated that "if disciplinary action is not carried out by the medical staff to the satisfaction of the governing board, the latter may in turn limit the privileges of the offending physician. . ." She places disciplinary action by the medical staff first, by the governing board second.

In the July 1955 issue of **HOSPITALS**, J.A.H.A., the late Malcolm T. MacEachern, M.D., wrote: "Medico-administrative management by the medical staff is manifested in self-discipline, self-education and self-appraisal."

In the January 1955 issue of **HOSPITALS**, J.A.H.A., Jack Masur, M.D., stated: "Physicians who have not completed the necessary in-

(Continued on page 119)



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HOSPITALS
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editorial notes

—trick or treatment

THE ADVENT of anesthesia was marked by those famous words of Dr. John C. Warren, uttered in the operating room of the Massachusetts General Hospital, on October 16, 1846:

"Gentlemen, this is no humbug."

A similarly dramatic statement could be made about hypnosis:

"Gentlemen, this is no parlor game."

Hypnosis has been used in medicine since Mesmer (1734-1815), but its popularity has waxed and waned, waxed as seeming miracles resulted and waned as the inevitable disappointment following its indiscriminate use occurred. As a vaudeville trick and as a game to enliven dull parties, it had the advantage of being easy to master and of producing dramatic results.

But in 1958, some physicians concerned about the use of this technique prepared a report adopted by the American Medical Association approving the use of hypnosis in medicine by persons qualified by experience and training to use it. The report recognized the therapeutic usefulness of hypnosis, but stressed the potential dangers.

The literature points out that hypnosis can be just as mischievious a tool as can a scalpel. The hospital is as duty bound to restrict hypnosis privileges to those qualified by training and demonstrated experience to use it as the hospital is duty bound to restrict surgical privileges by the same standards.

Harold Rosen, M.D., illustrated the perils in this case history:

"For instance, a compulsive smoker in her 30's was given a posthypnotic suggestion to cease chain-smoking. The suggestion was effective. She was grateful to her hypnotist, felt that he had "cured" her of cigarette smoking, and did not correlate her present distaste for cigarettes with the compulsive overeating that soon took its place. By the time she had added 40 lbs. to her weight, she sought out a second hypnotist who "cured" her of her obesity. She then—but much later—gradually began drinking more and more, found herself too intoxicated one day to attend to routine social commitments, and requested a third hypnotist to "cure" her alcoholism. To her, her compulsive chain-smoking, overeating, and alcohol intake were three completely unrelated problems. She spoke about each of her previous hypnotists in glowing terms. Her descriptions reminded one of quack cancer-cure testimonials made by patients a few months before they are hospitalized in extremis."*

There are three major reasons why hospitals should permit the use of hypnosis by competent medical practitioners only. These are:

1. To safeguard patients and to improve patient care.

2. To maintain a high standard of patient care by prohibiting use of hypnosis by nonphysicians or unqualified physicians.

3. To protect the hospital against the possible legal consequences of the misuse of hypnosis by physicians or its use by nonphysicians.

Safeguarding the patient's welfare should be the primary goal of the hospital and the physician. Therefore, hypnosis should not be used indiscriminately or carelessly, whether for anesthesia, analgesia, tranquilization or psychotherapy.

The physician who doesn't have the competence to do a complete psychiatric evaluation doesn't have the right to use hypnosis for functional disorders. Dr. Rosen tells of the dentist who quite successfully and safely hypnotized a patient for a dental extraction and then, at the patient's request, hypnotized her out of her smoking habit—but right into a severe psychosis.

The physician who undertakes to treat a pruritus with ointment is running little risk of severe injury. The physician who decides that the pruritus is functional in origin and, without adequate psychiatric training, treats it with hypnosis may be removing the one crutch which is keeping the patient from falling over the edge of a psychosis. Better to scratch than to go into a suicidal depression.

The competence of the physician employing hypnosis is not to be defined merely as the ability to induce a trance. This skill can even be taught by mail. Competence is defined to mean an adequate grounding in psychodynamics, the motivational bases of human behavior, a clinical judgment keen enough to sort out suitable and unsuitable subjects for hypnosis and a clear understanding of both the uses and limitations of hypnosis.

Hypnosis has a recognized place in medicine, but hypnosis must be placed within the general framework of psychodynamic psychology and psychiatry. Therefore, the use of hypnosis for therapeutic purposes should be restricted to those persons who are qualified to fulfill the necessary criteria essential to a complete diagnosis of the illness

(Continued on page 119)

*Rosen, H. Hypnosis—applications and misapplications. *J.A.M.A.*, 172:683 Feb. 13, 1960.

HOSPITAL EMERGENCY DEPARTMENTS:

TWO SURVEYS

Case study predicts load variation patterns

by ROBERT M. BARRY, M.D., with ERNEST C. SHORTLIFFE, M.D., and HOWARD J. WETSTONE, M.D.

According to the authors, the increasing number of patients using emergency room facilities and the changing patterns in patient care because of this should stimulate administrative and medical personnel to investigate the problem in their hospitals. The study of emergency room load variations at Hartford Hospital disclosed some interesting information, which, the authors believe, can be of practical value to other institutions conducting a similar study.

AN AWARENESS of the rapid growth in emergency department load and its significance in the changing patterns of patient care can do much to stimulate administrative and medical staff interest in emergency unit problems. Previous articles have discussed the increasing attention given to the emergency service at Hartford Hospital since 1954.[1,2] The creation of a joint emergency service committee on organization and management has resulted in better patient care as well as improved patient and public relations.

EMERGENCY SERVICE STUDY

The study made on patient load variations was designed to show when the peaks and valleys of activity occurred during the day, week and month. Concern over this problem came from the conviction that we could make better use of space, equipment, personnel and ancillary services if we knew what demands to expect and when to expect them.

This study was based upon the examination of records of 60,068 visits to the emergency unit from July 1, 1955 to July 1, 1958. The records were examined for the time of admission of the patient and the x-ray services involved. We were interested in the latter figure, in view of the frequent delays encountered by patients and physicians because the x-ray facilities were accessible only by elevator. It was our desire to consider whether or not the x-ray load was sufficient and predictable enough to warrant providing diagnostic facilities within the emergency suite itself.

SUMMARY OF DATA

From the mass of data collected, some 240 graphs were constructed to show total patient load variations and variations in the number of patients x-rayed. For convenience, the figures are expressed in terms of "patients per hour" as distributed by the hour, by the eight-hour interval and by the day. The distribution on weekdays was separated from that on Saturday and Sunday. The results of the study have been summarized into a series of 12 graphs, the value of

(Continued on page 39)

Robert M. Barry, M.D., is clinical assistant department of Surgery, Hartford Hospital; Ernest C. Shortliffe, M.D., is associate executive director, Hartford Hospital; and Howard J. Wetstone, M.D., is clinical assistant and senior research investigator, Department of Medicine, Hartford Hospital, Hartford, Conn.

THIS figure shows the increase in emergency unit visits as compared with outpatient department visits and hospital admissions.

Conflicting concepts of function shown in national survey

by JAMES R. McCARROLL, M.D., and PAUL A. SKUDDER, M.D.

A recent nation-wide survey of hospital emergency departments indicates a change in function for this service rather than a simple increase in number of visits for treatment of accidental injuries, the authors report. They describe in detail the methods used to obtain this data and offer some suggestions, based on the conclusions drawn, for smoother, more efficient emergency department service.

IN RECENT years the soaring costs of hospital care and the accompanying criticism of these costs by the public have prompted a series of critical self-analyses by hospitals of all aspects of their services. In this process of self-analysis, few hospital departments have fared as badly as the emergency unit. Justly or unjustly, emergency services have been characterized in such well publicized statements as, "the weakest link in the chain of hospital care,"[1] and "a frequent source of inferior patient care, and a prolific breeder of much adverse public relations."[2]

These and similar statements by respected medical leaders have been used by many lay publications as evidence that hospitals are failing to meet one of their principal obligations. This criticism ignores the fact that the functions and responsibilities of the hospital emergency service have been radically altered and expanded during the last 15 years.

INCREASED USE OF EMERGENCY UNIT

What was once the "accident room," designed to handle acute emergency problems, is now regarded, at least by the general public, as the appropriate initial source of medical care for a wide variety of medical, surgical, pediatric and even psychiatric problems. The resulting increase in emergency unit visits has been shown to exceed 400 per cent in many hospitals and in some, 600 per cent.[3] (See figure above.) It is obvious that this increased use of emergency facilities indicates a basic shift in patterns of medical care. Many of the reasons for this change are obvious, and both the medical profession and the hospitals themselves must share the responsibility for directly or indirectly encouraging these trends.

Although the increased utilization of hospital emergency facil-

James R. McCarroll, M.D., is assistant professor of public health and director, division of epidemiologic research, the New York Hospital-Cornell Medical Center; Paul A. Skudder, M.D., is assistant professor of clinical surgery and surgeon to the emergency unit, the New York Hospital-Cornell Medical Center.

This survey was sponsored by the American Hospital Association, American College of Surgeons and Cornell University Medical College.

ities has been well documented, the charges of a decrease in the quality of emergency medical care have not been similarly substantiated. In an effort to determine the actual quality of medical care given in hospital emergency facilities, the Cornell trauma research group joined the American College of Surgeons and the American Hospital Association to carry out a nation-wide investigation.

OBTAIN REPRESENTATIVE SAMPLE

To obtain a representative sample of all hospital emergency facilities, a two-stage sampling plan was employed. Representation from both urban and rural areas was needed, as was geographic distribution based upon population density. Four major geographic regions—New England and Middle Atlantic States, Southeast and South Central States, Middle West and Plains States, and Mountain and Pacific States—were used. In each of these regions, one major metropolitan area was selected for survey representation. All short-term, nonfederal, general hospitals in each of these major metropolitan areas were also included in the survey.

In addition to these major urban complexes, a number of minor metropolitan areas were also selected from each of the four geographic regions.

Since the demands upon emergency services in most urban areas vary with the number of facilities available, all hospitals in each major and minor metropolitan area were included. In addition to these urban groups, a random selection of hospitals in rural areas was also included.

This combination of stratified and random sampling techniques offered the best possibility for obtaining an accurate, representative sample for this survey.

EMERGENCY UNIT QUESTIONNAIRE

A questionnaire covering all aspects of emergency department care was submitted to the 330 hospitals surveyed. A total of 90 questions was asked of all hospitals, except for six additional questions which were asked only of hospitals in rural areas. These questions concerned the population served and the radius from which patients were drawn.

Response to the questionnaire was excellent (87 per cent), and the response from hospitals in the various geographic regions and population groups was remarkably uniform.

Almost all of the hospitals responding stated that they operated an emergency department, but many of those with negative responses also indicated that they provided care for many accident victims.

Of the rural hospitals surveyed, many stated that some patients came to their emergency departments from more than 25 miles away, and one hospital stated that patients came from as far as 400 miles. Half of the rural hospitals stated that the majority of their patients traveled more than 10 miles to the emergency unit.

Ambulance Service

Only a very few hospitals (6 per cent) in the survey group operated their own ambulance service. Most ambulance service is provided by organizations not under the control of the local hospital. Since hospitals have no responsibility for ambulance attendants, it is not surprising that few of these individuals are trained in first aid procedures.

The crucial gap between time of injury and arrival at a hospital emergency department is one area that needs improvement. Although the assignment of physicians to ambulance duty may not be defensible on economic or practical grounds, the obvious responsibility of the medical profession for the training and supervision of ambulance attendants should not be ignored. Certainly, elementary principles of first aid should be taught to all persons routinely serving on an ambulance team, and the practicing physicians in an area are the logical individuals to supervise this training.

Physical Plant

Two-thirds of the responding hospitals indicated that the physical plant of their present emergency unit was inadequate and that some structural changes were contemplated. However, most of these changes were planned by the larger metropolitan institutions. Only one-fifth of the rural area hospitals, which presumably include much of the recent hospital construction, plan changes for their emergency units. A check of such obvious aids as signs indicating the entrance to the emergency area shows none in one-fifth of the hospitals surveyed. In 37 of the 265 hospitals, the emergency facility was not even accessible from the street.

Equipment and Supplies

A thorough review was made of equipment, supplies and ancillary facilities. For certain expensive or rarely used items, availability in any area of the hospital is considered adequate, particularly in smaller hospitals where the supply areas are readily available to the emergency facility. A simple but most important procedure is to post the location of all equipment and supplies in some central and visible area in the emergency department.

Waiting Rooms

Since the emergency department is one area of the hospital which can generate more adverse public reaction than any other hospital facility, it is important to have a pleasant well equipped waiting room. Also, a simple brochure outlining the functions, limitations, responsibilities and fee charges of the emergency department should be included in the waiting room literature.

USE OF EMERGENCY UNIT

Seventy-one per cent of all hospitals surveyed replied that the function of an emergency unit should be restricted to the care of patients with actual emergency conditions. The remainder indicated that emergency departments could legitimately serve other functions, such as a screening or general clinic, either full-time or when the outpatient department is closed. In actual practice, only half of these hosptials were able to restrict their care to true emergency patients. Half of the hospitals stated their emergency facilities routinely performed such functions as caring for hospital personnel, or serving as a general clinic. Since many hosptals in this survey do not have outpatient departments, many emergency de-

partments are forced to assume additional functions.

Since the demands on emergency facilities now represent all aspects of medical practice, it is logical that supervision of an emergency service should be vested in a committee representing all clinical services, the hospital administration and the nursing department.

Another simple but important matter affecting the smooth functioning of an emergency facility is the posting in the emergency area of a roster of all physicians on call in the various specialties. An emergency department manual would also be useful in outlining simple procedures and practices to be followed and in serving as a reference source for newly assigned personnel. Only one-third of the hospitals questioned have prepared such a manual, and many of these neglected to include locations of vital equipment and supplies.

CLINICAL MANAGEMENT

A cross-check on the actual functions of the emergency department in the surveyed hospitals was provided by a series of questions on clinical procedures routinely performed in the emergency area. More than half of the hospitals stated such major procedures as the treatment of open fractures and the repair of tendon and nerve injuries were regularly carried out in their emergency departments. Hospital emergency facilities designed primarily for minor surgical procedures can rarely substitute effectively for a regular hospital operating room.

In addition to the use of hospital emergency units for major procedures, two-thirds of all hospitals questioned routinely permit the performance of elective minor surgery, and four-fifths of the hospitals surveyed use this area for nonemergent diagnostic purposes.

The widespread use of emergency facilities for nonemergent purposes can only occur at the expense of decreased efficiency in the care of actual emergencies. In general, major operating facilities in emergency units are found to be impractical and inefficient, but the authors believe that a complete minor operating unit is an essential part of every emergency department. High standards of asepsis, lighting and equipment and sterile technique should be rigorously maintained. Most hospitals indicated they adhered to these standards, and three-fourths of the hospitals initiate active immunization with tetanus toxoid as a routine part of treatment for open wounds in unimmunized individuals. Arrangements are made for completion of this series by virtually all hospitals, but unfortunately, the advantage is considerably dissipated by the fact that only one-fifth of all hospitals give the patient a written record of this immunization.

EMERGENCY UNIT RECORDS

Usually, previous medical records are available to the emergency department. However, a record of treatment administered to a patient in the emergency unit does not become a part of his chart in 25 per cent of all hospitals surveyed. Potentially, this could cause a serious complication if the surgeon caring for the patient in the hospital had no knowledge of what treatment had been administered in the emergency unit. An indication of the possible inadequacy of many emergency unit records is the fact that only half of the hospitals surveyed included emergency facility records in routine medical record auditing.

SUMMARY OF EMERGENCY UNIT DATA

Each hospital in the survey was requested to keep a running tabulation of all emergency unit visits for a period of one week. The compilation of these reports showed several interesting aspects of the emergency unit care. A breakdown of the types of cases seeking emergency care was as follows:

1. General Surgery	27 per cent
2. Medicine	27 per cent
3. Pediatrics	14 per cent
4. Orthopedics	14 per cent
5. Other	18 per cent

Of all patients visiting the emergency unit, 42 per cent were considered to have nonemergency problems, and 18 per cent were subsequently admitted to the hospital as inpatients. Accidents accounted for one-third of all emergency department visits. A breakdown of emergency unit visits by shifts is shown:

1. Day shift	47 per cent
2. Evening shift	40 per cent
3. Night shift	13 per cent

Although the case load during the evening shift is almost as great as that during the day, the personnel available to care for patients is considerably reduced during the evening hours.

Although only 14 per cent of the patients were pediatric cases, 29 per cent were under 15 years of age. It is interesting that the increase of 22 per cent in Saturday and Sunday visits was due almost entirely to children and adolescents. Adult visits showed no significant increase on weekends.

DISCUSSION OF DATA

The present survey indicates that the increasing number of visits to hospital emergency departments represents a change in function of these facilities rather than a simple increase in visits for accidental injuries. Since two-thirds of all emergency unit visits are for conditions other than accidental injuries, the public obviously looks to the hospital emergency unit for medical care for a wide variety of illnesses. Actually, 42 per cent of all emergency visits were considered by hospital personnel in this survey to be nonemergent. Despite this evidence of widespread use of emergency facilities for routine medical care, nearly three-fourths of the hospitals surveyed thought that their emergency facilities should restrict activities to the care of true emergency problems. These conflicting concepts of emergency unit function are obviously responsible for many of the problems in emergency department administration. Some of these difficulties could be resolved by the formulation of an acceptable definition of emergency department responsibilities and functions.

Nevertheless a major problem faced by the emergency department is the kind of treatment traumatic injuries receive before the patient arrives at a hospital. Unfortunately, medical care during the critical period is frequently given by an

individual with inadequate first aid training. If this situation is to be corrected, the medical profession must assume full responsibility for directly or indirectly supervising the training of ambulance attendants, policemen and other individuals who will be called upon to render emergency care.

Finally, an important part of the immediate care of the accident victim includes the recording of pertinent observations and a brief description of the treatment rendered. This information should be given to the emergency unit physician and should become a part of the patient's permanent hospital record. ■

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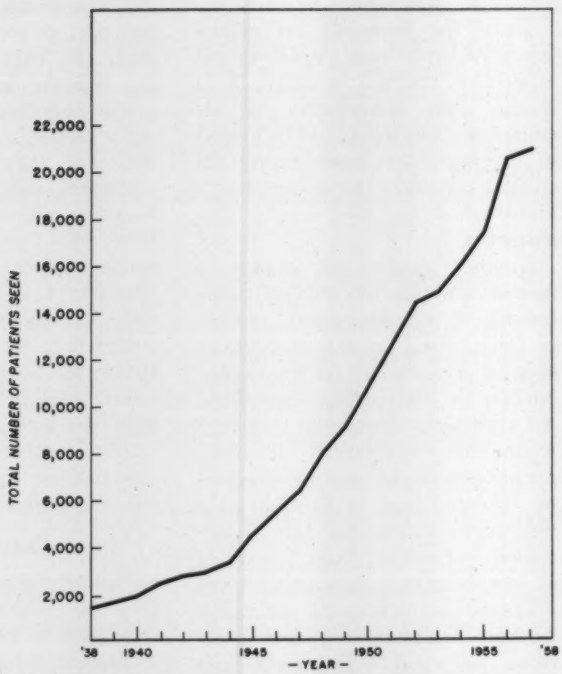

Fig. 1—Number of patients seen in emergency room from 1938-1957

Case study predicts load variation patterns

(Continued from page 34)

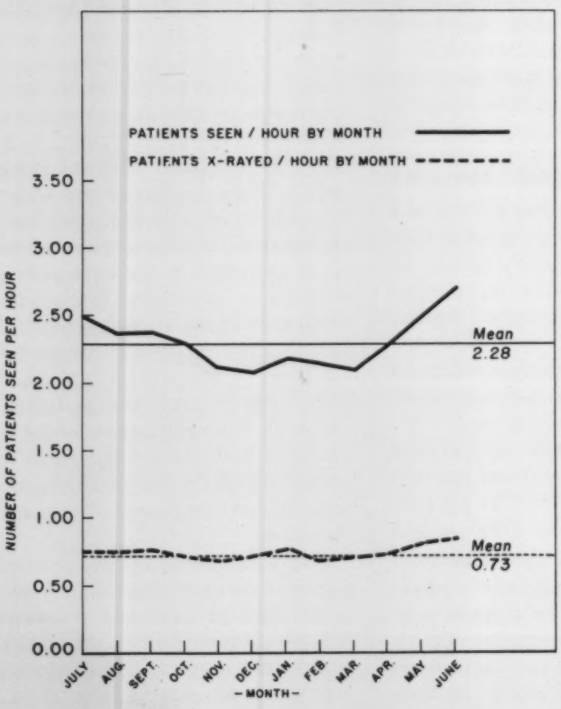

Fig. 2—Total period studied and number of patients seen per hour

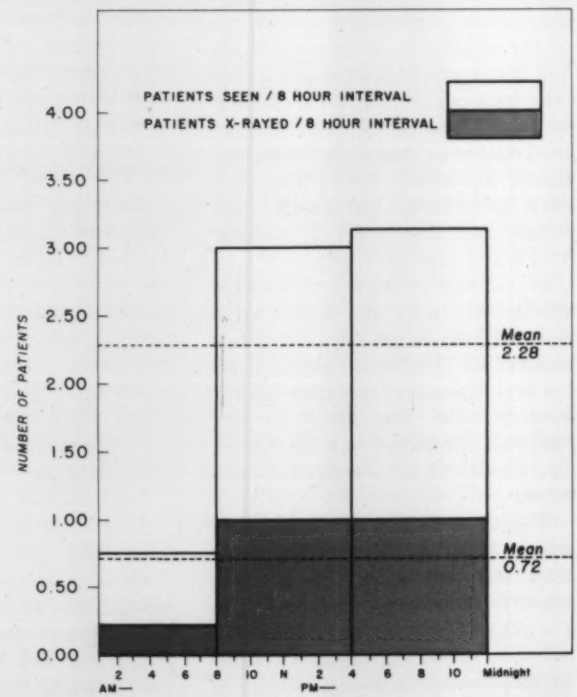

Fig. 3—Hourly variations in patient load

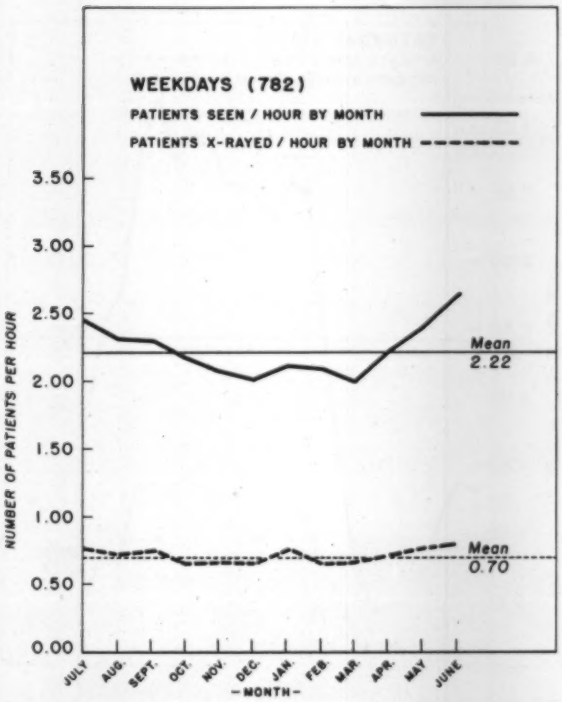

Fig. 4—Seasonal distribution of patient load

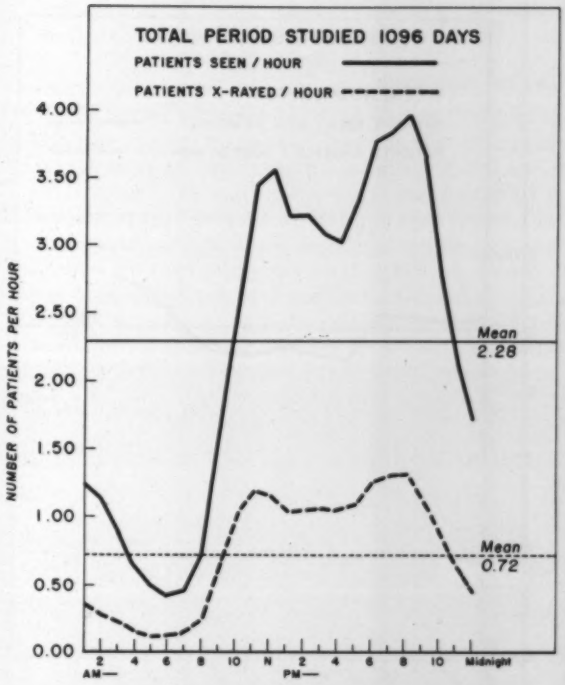

Fig. 5—Weekday distribution of patient load

which becomes apparent as they are studied. It must be emphasized that these graphs are not presented with any suggestion that they have a universal application. Each hospital's emergency load differs from that of many or all others. However, administrators and members of medical staffs will find this study to be of value in making decisions in emergency service organization in their own institutions.

DISTRIBUTION OF PATIENT LOADS

The distribution of patients seen in the Hartford Hospital emergency department is presented, because it shows a pattern similar to that seen in many other hospitals. Although the rise in total patient load from 1938 to 1957 is shown (see Fig. 1, p. 38), particular attention should be called to the increase occurring from 1944 to 1948 and the almost constant gradient since that time. The plateau which appears in 1957 has not persisted. Our estimate of the patient load at Hartford Hospital for 1961 is in excess of 30,000.

Figure 2 (see p. 38) shows the total period (1096 days) studied and the number of patients seen per hour. A mean of 2.28 patients per hour is noted. Of these, 0.72 patients were x-rayed per hour, or 31.5 per cent. Peaks occurred in both cases shortly before noon and from 6 p.m. to 9 p.m. For 14 of the 24 hours (9 a.m. to 11 p.m.), the hourly rate was equal to or exceeded the mean. Particular attention is called to the percentage of patients x-rayed as illustrated by this and subsequent figures; and to the fact that if hourly analysis had not been performed, significant peaks of activity would have been missed.

The hourly variations on the 8-hour or "shift" load shows (see Fig. 3, p. 38) that the evening (3 p.m. to midnight) hours are the busiest in the emergency room. Again, the number of patients x-rayed equals 31.5 per cent.

The seasonal distribution of patient load variations above and below the means is shown in Figure 4, above. Attention is called to the relative stability of load and to the interesting peak in summer rather than winter activity.

Parallelism between patients seen and patients x-rayed is shown, the latter constituting 32 per cent of the former. There is a pattern similarity to Figures 5 and 6, page 40. In Figure 5, the seasonal variations during weekdays is shown while Figure 6 shows the week end variations. Both figures show the same peak periods as seen in Figure 4. The number of patients x-rayed during the week equaled 31.5 per cent of the total seen; the number x-rayed on the week end was 30.4 per cent.

SIGNIFICANT LOAD DISTRIBUTION

The particular significance of Saturday and Sunday load distribution is shown in Figures 7 and 8. These charts show a flurry of activity which occurs from midnight Friday until two or three o'clock on Saturday morning. This is followed by a steady decline until 8 a.m., when a sudden increase in activity occurs and persists throughout the day, falling below the mean at approximately 11 p.m. A parallel "x-ray line" and the relationship of 31.8 per cent can be seen.

The drop to "mean," as shown in Figure 8 p. 40, on Saturday night is maintained until a new peak develops beginning at 8 a.m. Sunday. This starts its decline about 8 p.m., somewhat earlier than on Saturday night. The parallelism persists in the two graphs, and the percentage equals 31.7.

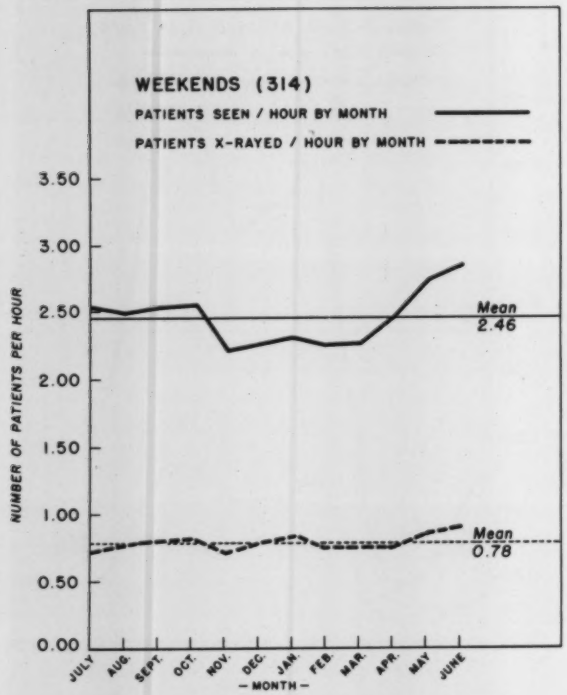

Fig. 6—Weekend distribution of patient load

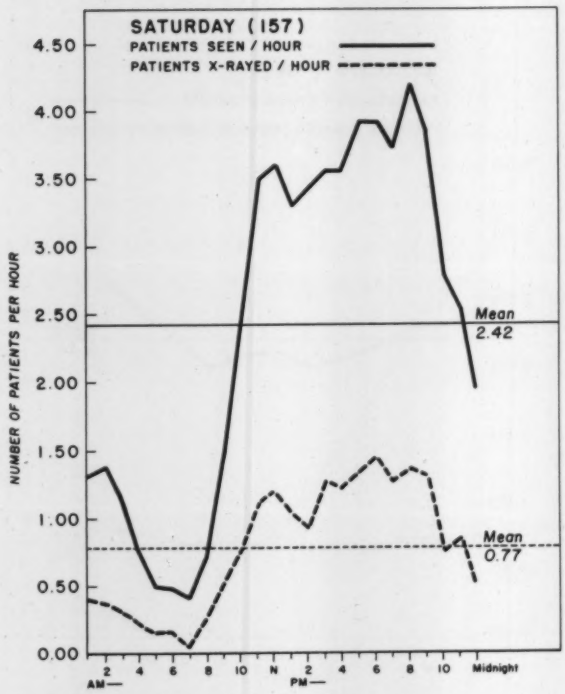

Fig. 7—Saturday load distribution of patients

The hourly distribution on weekdays (Fig. 9. below) shows a fall well below "mean" from about 11 p.m. until 5 a.m., with a peak well above "mean" at noon and again in the early evening. There is a decline after lunch and a rise in the late afternoon. The parallel x-ray graph "shadows" the main graph at an average of 31.5 per cent.

Shift variations on Saturday are shown in Figure 10, p. 41. Once again, x-rayed patients equaled 31.8 per cent of total seen. Shift variations in patient load for Sunday are shown in Figure 11, p. 41. A drop off at the end can be seen.

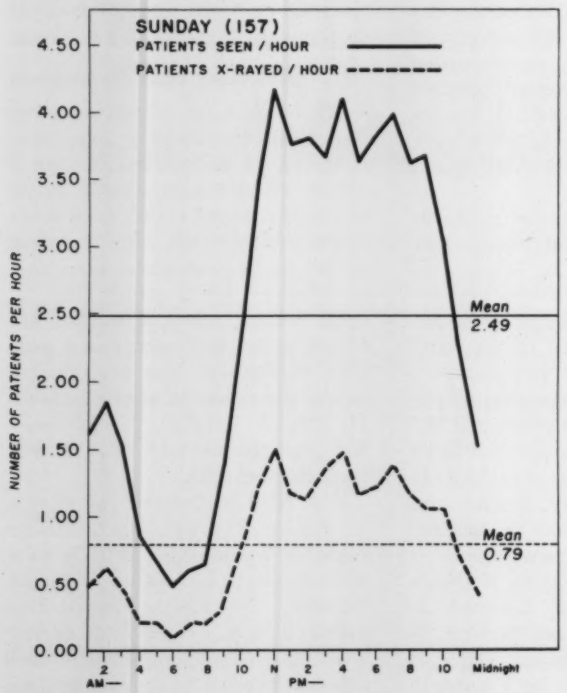

Fig. 8—Sunday load distribution of patients

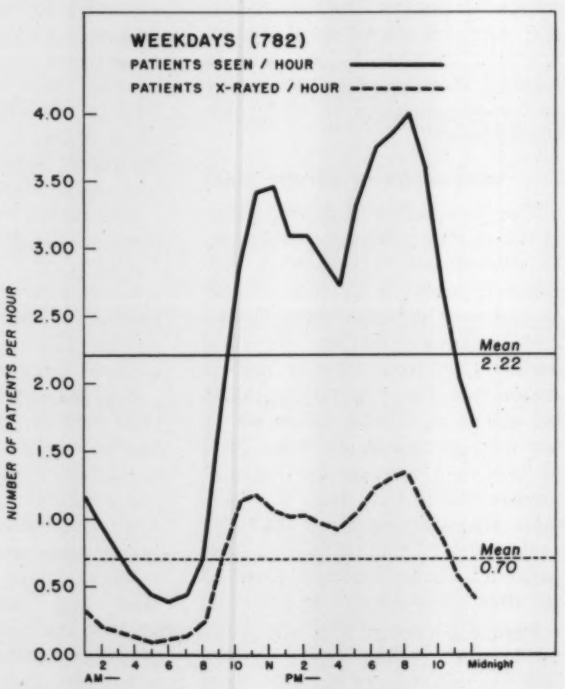

Fig. 9—Weekday hourly distribution of patient load

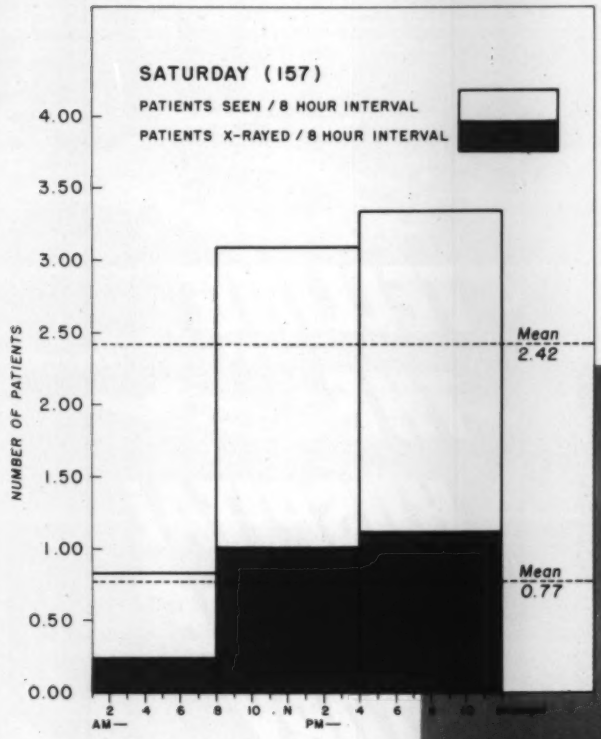

Fig. 10—Shift variations on Saturday

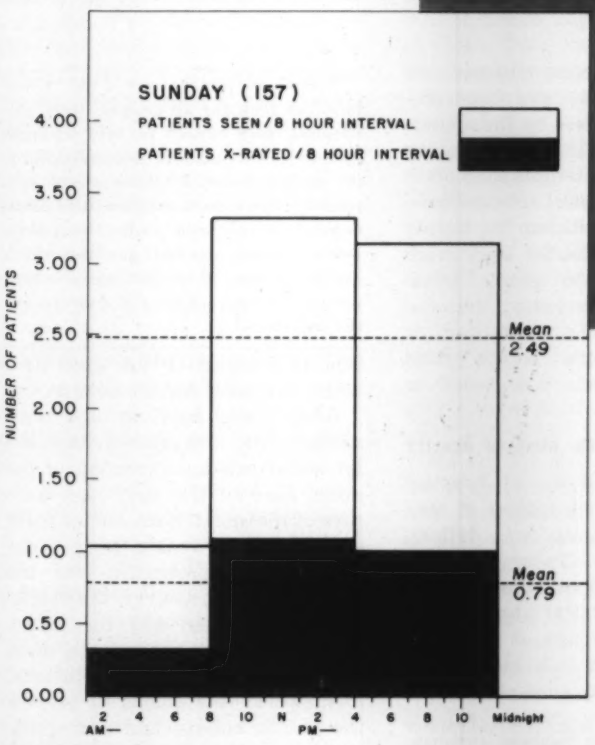

Fig. 11—Sunday shift load variations

Weekday shift loads (Fig. 12) follow a pattern similar to that found on Saturday.

DISCUSSION OF DATA

This series of graphs clearly shows the fluctuations occurring in patient load in the emergency department of one general hospital. Contrary to expectations, patient visits were not found to be more frequent during the winter when more falls, fevers and car and home accidents can be expected. Rather, an interesting seasonal peak was found. It has been suggested by some that one of the reasons for rising patient loads in emergency departments leading to a changing pattern of patient care is the

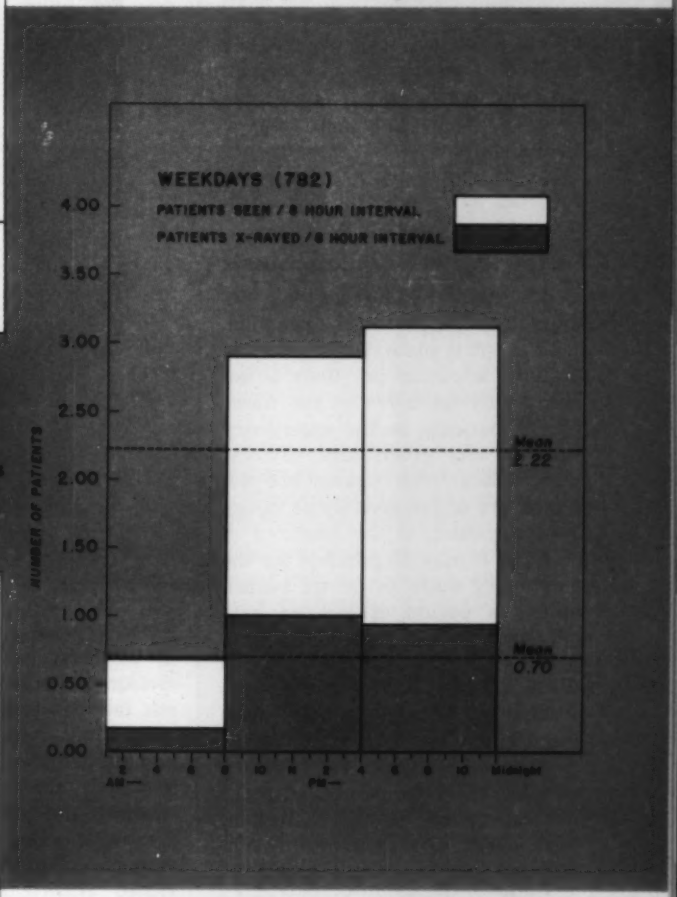

Fig. 12—Weekday shift load variations

periodic unavailability of doctors because of daily work habits, weekly days off and seasonal vacations.

Of greater practical significance, however, are the fluctuations over the day. The findings indicate that, in the Hartford Hospital emergency department at least, a persistent pattern of activity can be expected. Moreover, these findings establish that the "mean" will be exceeded in terms of patients per hour over the greater portion of every day, i.e., from approximately 8 a.m. to 10 p.m.

RELATIONSHIPS BETWEEN PATIENTS

We found the constant relationship between total patients seen and those x-rayed dramatic. If an emergency department is overloaded with patients

waiting to be x-rayed, a problem is created by the lack of available space, and quicker service seems desirable. However, the problem can be more easily assessed if a predictable relationship between the number of patients seen and the number x-rayed is established. The persistency of the 31 to 33 per cent relationship has permitted us to consider the potential x-ray load, which will arise in the emergency department at Hartford Hospital as the total patient load is projected to some 30,000 in 1960, approximately 37,000 in 1962 and well over 40,000 in 1965. If our figures are correct, the emergency x-ray load will exceed 12,000 patients per year—a sizable number, and one which has led us to plan for emergency x-ray facilities as an integral part of an enlarged emergency suite.

CONCLUSION

It is apparent that we have examined only a part of the problem.

In the first place, the number of patients admitted per hour is not necessarily an index of the number of patients *in* the emergency suite at any given time. By the same token, such figures are not a measure of the severity of injury and, therefore, of the intensity of activity. It may be possible for the emergency suite to be its busiest during a period of low patient-per-hour activity.

Recognition of this fact has led us to consider this study a preliminary approach to one which may prove equal to or even greater in significance. The new study is to be concerned with the clinical nature of the pattern of load based upon the medical or surgical specialty involved and the severity of illness as measured by the complexity of its management.

Meanwhile, our immediate study will be used in attempting to resolve such problems as x-ray coverage, staffing patterns and the provision of other ancillary services. It already has been valuable to us, and we believe that results obtained by similar studies in other institutions will confirm the benefits gained. ■

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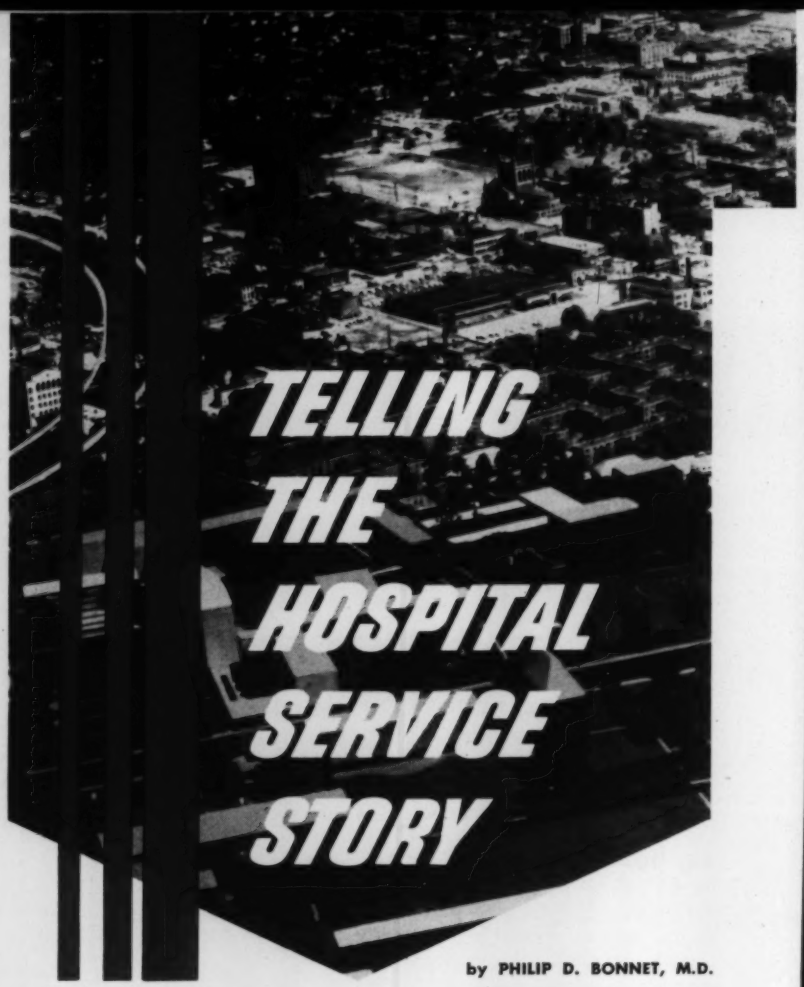

TELLING THE HOSPITAL SERVICE STORY

by PHILIP D. BONNET, M.D.

Today's hospital is part of the "Good Life" we seek for all people; thus, the hospital story cannot be told through statistics, economics or generalizations, the author states. Physicians and hospitals together must explain their interdependent role and make the public aware of those spiritual qualities which are the essence of medical care—warm personal relationships and concern for the individual.

FOR SEVERAL years, trustees and administrators have been increasingly perplexed by the apparent lack of public understanding of hospitals. As attempts to explain and interpret hospital services have increased, the criticism of hospitals has grown louder and more frequent. Like so many other forms of criticism today, it is directed against the institution or groups of people rather than against individuals who work in hospitals.

STATISTICS: DUST OF REALITY

What is the story of hospital service? It is not a matter of statistics—beds, admissions, dollars, tests and so on. These are only lifeless abstractions, the dust of reality. The hospital story is inspiring, even though it may not be glamorous. It is a major part of the forward advance of civilization. It is a part of the "good life" which we seek for all people.

After mere survival and subsistence, the concerns of men are for social order, cultivation of the mind, care of the body and nurture of the spirit. Each one of these concerns is the reason for the existence of a profession—for the existence of the lawyer, the teacher, the physician and the priest. For each of these professions, there has been developed an institutional framework—the courts of justice, the school, college and university, the hospital and the church. All

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the meaning and values of civilization are wrapped in those concerns of mankind. Civilization as we know it depends on the interaction of all of these; not on one or two alone. All manifestations of material prosperity and economic progress are insignificant in comparison, for they are dependent on these fundamental concerns of men everywhere.

WHY, WHEN, WHERE, WHO?

If it is true that the profession of medicine and its institutional form, the hospital, are one of the pillars of our civilization and standard of living, why does the story need to be told? Why is it so difficult to tell it?

The reasons are many and complex. Among some are: the difficulty of being heard amid the clamor of competing voices, the depersonalization of our society by the search for objectivity and the attempt to be "scientific". There is evidence of confusion, fragmentation and distortion in the public mind. There is a disassociation between the necessary means and the desired ends. But mostly, the story is not being told in understandable, meaningful terms. The truth must fight to be heard but it must be the truth.

When and where should the story be told? At all times, in all places and over and over again. It is naive to think that once the story is told, the task is done. The task is never done. The story must be told again and again—coherently, inspiringly and with a missionary zeal. The good things of life are usually taken for granted, especially in times of prosperity. We must remind ourselves first of this peril, for only then can we dare to remind others.

Who should tell the story of hospitals? Everyone should; everyone who believes in hospitals and who cares—administrators, patients, employees, and most of all, physicians and trustees. It is they who are in the best position to lead and inform the opinion of people regarding the hospital and its importance to society. It is also they who appear to be the most vocal critics in public, not of their own hospital, but of hospitals in general.

The crux of the problem, however, is: What is the hospital story that should be told? As in dealing with heresies, it is easier to tell what the story should not be. So let us consider first what this story is not.

First of all, the public story should not be economics—dollars, head counts, averages. We should cease attempting to explain hospitals to the general public in economic terms as if the whole problem were one of enough money. For 30 years our society has been preoccupied with the search for security and equality through economics. Hospitals have not been immune from this preoccupation with a crude impersonal counting of chips. Costs and prices are not the hospital story.

We administrators must understand the economics of hospitals and be prepared to explain the story in those terms to knowing people at the right time and place. We should not, however, fall into the trap of thinking that the public will accept or understand that sickness and health are merely matters of dollars and cents. Money is only a means to an end, not an end in itself. The public seems to understand this, but do we?

We should also be careful that the Blue Cross idea does not confuse the question. Blue Cross is an economic device and a means to a desirable end, but it is not an end in itself. Blue Cross publicity should also avoid overemphasis of statistical abstractions and economic matters.

The negative public attitudes toward increases in Blue Cross rates should surprise no one. The public is not consistent nor logical in its decisions on economic questions. Of course, the public wants more service and greater convenience, but when the question of paying more for it arises, the initial reaction is a loud "No". Railroads are a good example: would the public eliminate trains and close stations? No. Raise fares? No. Auto accident insurance is another example: would the public want higher premiums? No. The public reaction in Blue Cross rate hearings repeats a familiar pattern. There should be preparation in advance for such reaction.

A STORY OF PEOPLE

Second, the story of hospitals is not one of generalization and abstractions. It is a story of warm personal human relationships—of dedicated skilled people who care and who know how to help people who are sick and injured. It is a story of sick people recovering from serious injury, from cancer, from pneumonia. It is the control of diabetes and the recovery from a disabling heart condition. It is comfort and concern for the dying when human knowledge and skill are insufficient.

It is students, nurses and physicians learning to help sick people. It is physicians perfecting techniques and making new discoveries for better care tomorrow and next year. These things make a hospital. Hospital service is not so many transfusions, so many medicines issued. Hospital service is people—sick people recovering from their sickness and being able to return to their families and jobs.

Third, the story of hospitals should neither be arrogant in promising too much and talking glibly in superlatives nor inversely arrogant by clothing the hospital with an aura of infallible mystery. The concern for individual privacy is right when properly used, but it can create an unintended impression of disdain and aloofness.

Fourth, the story of hospital service should not imply a smug, complacent, unique mission of the hospital as the answer to all human ills, social as well as physical. A review of the hospital literature suggests that great effort has been made for many years to identify and establish a unique special mission of the hospital which is separate and independent of the physician. It is time, however, for us to recognize that the hospital has no such mission.

The story that should be told is that hospitals have a partnership with physicians, very much like a marriage. The physician is the active, episodic, aggressive male principle; the hospital is the passive, continuous, safeguarding, nourishing female principle. Modern health service requires both principles acting together; neither alone is self-sufficient. To change the metaphor, the hospital is a highly complex, sensitive and, on the whole, efficient instrument fashioned by society and placed at the disposal of the physician to enable him to care effectively for sick people. Without a hospital, today's physician is relatively helpless in dealing with severe illness. Without the physician, the hospital is not a hospital and in fact has no purpose.

The dependence of physicians on hospitals is a relatively new thing in our society. The physician formerly was a carefree bachelor in his relations with hospitals. Specialization and the developments in medical technology have made marriage a necessity—no matter how reluctant the recognition of this state of affairs may be.

A HOSPITAL: CONTINUOUS HARMONY

Using another figure of speech, the hospital can be likened to a large symphony orchestra made up of several smaller orchestras. Each player is a skilled musician ready to play whatever music is provided when the cue is given by the conductor. Unlike the symphony orchestra with one conductor, the hospital has many conductors directing parts of it simultaneously and writing the music as they conduct. The themes vary from simple folk tunes to full symphonic choruses, with many phrases and themes repeated but in varying sequence and in unpredictable combinations. From this orchestra must come a continuous outpouring of harmony, with no respite and no margin for error. Individual players leave their places temporarily and other players relieve them, but the music continues unceasingly.

The hospital service story must place the physician in the center of the picture in true perspective. It is he and only he who calls forth the services of the hospital.

In presenting the hospital story, it should be remembered that our society has accepted health services among the basic necessities of life together with minimum subsistence needs of food, clothing and shelter. Care of illness is now considered an integral right of citizenship rather than an individual choice. The fact that such a goal is not attained at all times in all places in our country does not negate its validity.

NO HEALTH CARE MINIMUM

Health services, however, differ significantly from the other basic necessities. There is no minimum when treatment in a hospital is involved. There is only one essential standard of service applicable to rich and poor alike—the drugs, the x-rays and the nursing must all be the same. In addition, the need for medical and hospital care is variable and unpredictable in time and in amount. This care is expensive because of the complexity and high degree of skill involved. The need for food, clothing and shelter recurs daily and is for the most part predictable. For these reasons, the problem of financing medical and hospital care is a more complex matter than for other necessities, particularly when one remembers the obligation to provide the service whether paid for directly or not.

A significant part of the hospital story is the central importance of the individual. Medical care cannot be standardized and mass-produced. The essence of medical care must remain as the individual decision of the individual physician about the individual patient. It has been said that the profession of medicine and the hospital are the last strongholds of the concern for the individual in our society. Whether this is wholly true or not, the central concern for the individual is an essential part of effective, responsible medical and hospital services. In this regard, physicians and hospitals are swimming against a powerful tide, but there are indications, in education at least, that differences among students are being recognized as important. The tide may be turning.

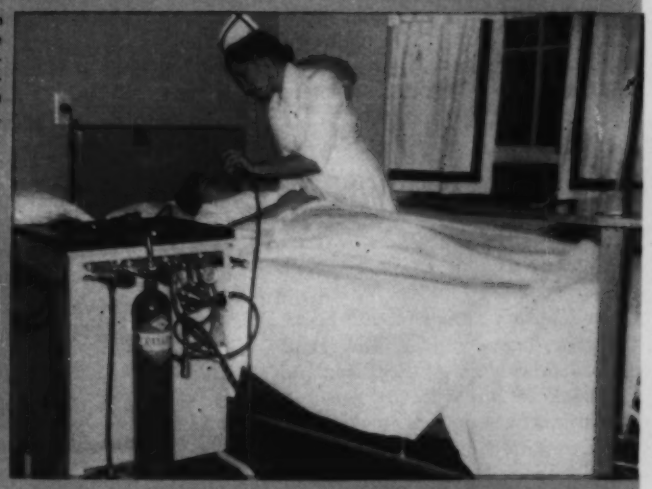
HOSPITALS: VICTIMS OF SUCCESS

It has been wisely said that physicians and hospitals are victims of their own excellence and their successes. The record of success has been impressive. The vitality of the hospital idea has been demonstrated throughout our nation. Hospitals have grown in numbers, in size, in quality, in scope, in differentiation and in adaptation—all signs of a vigorous vitality.

The public's concern appears to be centered on two aspects of hospitals and health services. The first concern is, "Will they be available when my family needs them, and how can they be paid for?" The second is, "Why cannot hospitals be more warm and friendly and personal?" In both of these concerns, there is a large element of fear of illness which we must recognize in ourselves and understand in others. There is also an apprehension about being treated as a "thing" rather than as an individual person.

Hospitals do well in their relations with patients. Unsolicited expressions of thanks and gratitude and of appreciation and understanding from former patients outnumber many times over the critical and unfavorable complaints. Hospitals do not do as well, however, with the members of the general public who are not sick and who do not wish to be sick. Understanding of the hospital by them is difficult, but constant efforts must be made to cultivate that understanding.

Difficult though it may be, the hospital service story can and should be told by physicians and hospitals together, and both their roles should be made clear. ■



AN OPERATING room nurse demonstrates the use of the portable recovery table as she administers oxygen to a postoperative patient.

Rolling recovery 'room' follows patient to bedside

by ROBERT V. FAY

A portable table which can be wheeled to the bedside of the patient and which carries postoperative recovery equipment can provide efficient and economical recovery room procedure, the author states. He describes how this table can be constructed and gives a detailed list of supplies and equipment that it should hold.

THE COMMUNITY Memorial Hospital, Ayer, Mass., in investigating the current strengths and weaknesses of the hospital's equipment and patient care techniques, found that several areas of service in the hospital had outdated equipment and were seriously lacking in space. However, any recommendations by the long-range planning committee, including members of the board of trustees, representatives from the medical staff, the administrator and the director of nursing, were to be premised on the planned future growth of the hospital from 40 beds to 85 to 100 beds.

One area which needed improvement was the surgical wing. Here a recovery room was considered a necessity even though everyone concerned—patients, nurses and medical staff—agreed that the current postoperative recovery procedures were quite satisfactory. But, when the plans were drawn and the building costs developed, it was apparent that the expenditure would be very uneconomical in view of the long-range planning program, which called for the building of a new surgical floor complete with operating room suite and recovery room. Yet, it was evident from the literature that postanesthesia recovery areas were highly desirable, even in smaller hospitals.*

With these facts in mind and an acceptance of the theory that this hospital should at least match the patterns of care generally prevalent in a geographical area or for any similar type of institution, it was decided that the way to solve the problem was to make recovery facilities available in a manner that was suitable for the smaller hospital.

The administrator, the director of nursing, the medical staff, the chief of surgery and the senior anesthesiologist all agreed that a portable recovery table would be an important asset for improved patient care. It would also help economize the use of doctors' and nurses' time and talents in surgical emergencies. It was stipulated, however, that the equipment should be arranged so that it would be at a patient's bedside from the time he returned from surgery until he "recovered," and that a registered nurse trained to handle the unit would remain with the patient during this period.

The administrator suggested to

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*Part 2 of the Guide Issue, HOSPITALS, J.A.H.A., Aug. 1, 1959, gives the following data:

1. 42 per cent or 2773 of all reporting hospitals have postoperative recovery rooms.
2. 40.6 per cent or 2470 of the nonfederal hospitals have such facilities.
3. 51.1 per cent or 2206 of the voluntary, or short-term, general hospitals have recovery rooms with 15.5 per cent of the 208 hospitals in the 25 to 49 bed category included in the totals.

the president of the hospital's auxiliary that the auxiliary underwrite the cost of the unit. The members of the auxiliary gave their enthusiastic support and allotted sufficient funds to meet the expense.

MAKING THE RECOVERY TABLE

A regular bedside table was selected as the unit on which to mount practically all the necessary equipment and in which to store the appropriate supplies. This particular unit was selected because the rear legs extended at a right angle some eight inches beyond the back of the table. It was felt that this would both protect equipment mounted on the back of the table and cut down damage to walls and door frames.

At first, it was decided to mount a suction machine on the table, but an explosion-proof unit was needed. Meanwhile, a portable resuscitation unit came to our attention. Because of its versatility and virtual elimination of the static electricity problem (the unit is activated by the oxygen flow, making it completely portable), the unit was bought, minus the carrying case.

The attachments for two "E" (22.05 cu. ft.) tanks of oxygen were mounted on the rear of the table, and a "shoe" was custom-built and secured to the bottom frame of the table to support the base of the tanks and to take the weight off the comparatively light sheet metal back of the table.

In order to guarantee a fairly quiet and even movement and to be certain of elevator clearance, five-inch casters were installed on the legs of the table.

The single-drawer unit in the front of the table was converted into two drawers, and dividers were made so that medications and the many necessary small supply items could be kept segregated and ready for immediate use.

An adaptation of the basic resuscitator unit was made so that either piped wall oxygen or large tanks (244 cu. ft.) could be used. It is generally estimated that the amount of oxygen in the small tanks is sufficient for only 25 to 35 minutes. This should be plenty for most emergencies, but wall outlets and the larger tanks are considerably less expensive and make it possible to use the table for more extended periods.

The various items mounted on, or carried in this table are listed in Table 1, below.

In addition to the supplies and equipment listed in Table 1, a tracheotomy set is always kept ready in the central sterile supply room and a cardiac pacemaker and cardiac arrest tray are always in a designated location in the major operating room.

The potential of this recovery unit has not yet been fully explored, but the following is an outline of what we think are good reasons for investing in a portable table of this type.

1. Patients can be resuscitated because a full resuscitation and inhalation cycle is furnished. This equipment automatically "breathes" for the nonbreathing patient suffering from respiratory failure or asphyxia by delivering oxygen at 12 mm. positive pressure and "exhaling" at 9 mm.

Table 1—Portable Recovery Table Equipment and Supplies

		Quantity
I.	**Medications and solutions**	
	Methoxamine hydrochloride—20 mgm.	5 amp.
	Levarterenol bitartrate—0.2% solution	2 amp.
	Ephedrine sulfate—50 mgm.	5 amp.
	Epinephrine—1:100 solution	5 amp.
	Caffeine and sodium benzoate	3 amp.
	Theophylline ethylenediamine injection (I.V.) 0.25 gm.	2 amp.
	Theophylline ethylenediamine injection (I.M.) 0.5 gm.	1 amp.
	Lidocaine hydrochloride—1%	1 vial
	Lidocaine hydrochloride—2%	1 vial
	50% Dextrose	2 - 50 c.c. amps.
	Dextrose 5% (in ¼ strength saline)	2 - 500 c.c.
	Isotonic sodium chloride	1 - 500 c.c.
	5% Dextrose in water	1 - 500 c.c.
II.	**Syringes**	
	(in size)	
	20 c.c.	1
	10 c.c.	2
	5 c.c.	2
	2 c.c.	5
III.	**Needles**	
	(in size)	
	16	5
	18	5
	20	5
	21	5
	25	5
IV.	**Other Supplies**	
	Alcohol sponges	any
	Tongue blades	any
	Blood collection tubes	any
	Blood administration kits	4
	Pressure set	1
	Secondary blood administration sets	2
	Suction catheters	3
V.	**Specialized equipment**	
	Airways	3 - 1 size 0 1 size 2 1 size 5
	Tracheotomy adapter	1
	Tracheotomy tube adapters (2 types)	4
	Resuscitator tubes	2 - 1 adult 1 pediatric
	Face masks	4 - 1 large 2 medium 1 small
	Oxygen gauge	1
	Oxygen wall connections	1
	Nasal oxygen inhalation setup	1
	Resuscitation head	1
	Blood pressure cuff	1
	Stethoscope	1
	Tourniquet	1
	Oxygen tank	1
	Suction setup	1

(LEFT) In this picture, a nurse explains the special equipment and supplies carried in the recovery table, and other nurse tests the resuscitator "head". (BELOW) During an inservice training program for using the portable recovery table, a supervisor demonstrates how oxygen is run through water, while another nurse shows the preparation for using straight nasal oxygen.

negative pressure. At our hospital, the original "head" of the unit has been replaced with a unit that is suitable for both adults and infants. The resuscitator adjusts automatically to the patient's lung size or volume and has an internal signal which indicates if oxygen is not reaching the lungs. It also has a safety relief valve which protects the patient against any excessive pressure.

2. This "head", operated by small "E" tanks of oxygen, may also be used for straight inhalation of oxygen for 25 to 30 minutes until routine therapy is set up and oxygen flow is received from a large tank or a wall oxygen outlet.

3. The patient can also be aspirated. If more than "light" suction is needed, a regular suction unit could be supplied promptly. This aspirator is used to clear the patient's airway of vomitus or excessive mucus present in the nasal or oral passages.

4. Oral-nasal oxygen can be given with nebulization. This unit facilitates the use of a humidifier with nasal catheter or mask. It can be used with a nebulizer if aerosol therapy is needed.

5. A very complete selection of life-saving medications and intravenous solutions is kept stocked in the table. (Note: This equipment may be used for more than one patient at a time. It is possible to resuscitate or aspirate one patient and at the same time give oxygen therapy to a second patient. It could also be used to aspirate one patient while another patient is being resuscitated and oxygen is being administered to a third patient.)

The director of nursing at Community Memorial Hospital summarized the nursing evaluation of the unit in the following way:

"The patient recovery table has helped our nurses give better nursing care during the recovery period. It is complete so that, once at the bedside, all is in readiness for good recovery practice. The unit is simple enough to operate, and instruction in its use is relatively easy. Not only have we found it valuable for postanesthesia patients but also we have had occasion to use it many times on our medical patients as well. It has given our nursing staff a sense of security in knowing that the recovery table stands ready, fully equipped to meet emergencies as they arise."

The anesthesiologist has evaluated the table and procedures as follows:

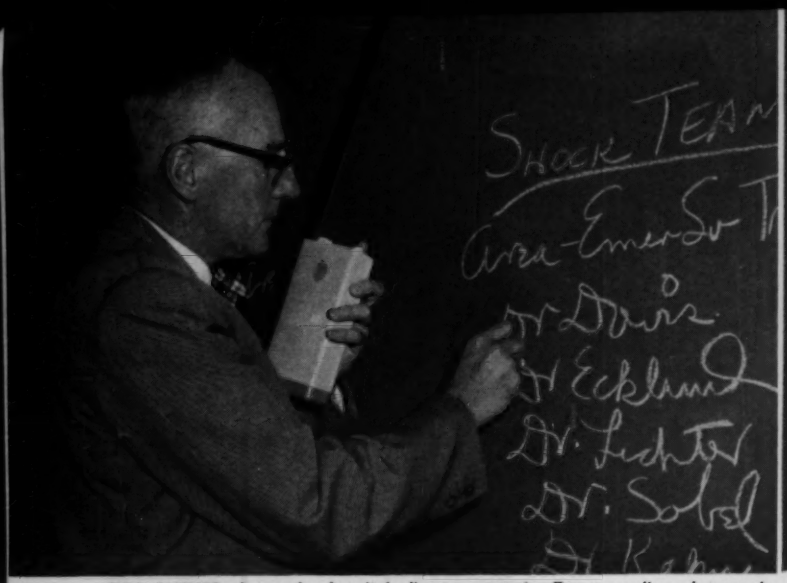
"The recovery table provides equipment and drugs for initiating resuscitation and maintaining the efforts in all but the most extreme problems. Instruments for thoracotomy and a cardiac pacemaker are readily available.

"The training and ability of the personnel using the equipment determine the degree of its success. Nurses and physicians using it have been pleased with its ability to help them give care promptly."

It is quite apparent that the usefulness of the unit has only been touched upon. This unit could be wheeled with the patient to his room when the recovery rooms of larger hospitals are closed in the evening. Perhaps it has value in pediatric units, or in the nursery. The emergency department also is an appropriate area for its use.

SUMMARY

The completely equipped portable postanesthesia recovery table with a staff trained to handle the equipment can be a very important part of an acceptable solution to the problem of improving postoperative care, especially in the smaller hospital. If the surgical schedules were to increase appreciably before a recovery room as such is built, our needs could best be met by two of these units. ■



THIS PICTURE shows the hospital disaster control officer recording changes in disaster teams on the blackboard as he orders these changes via the walkie-talkie.

WALKIE-TALKIES IN THE DISASTER KIT

by GERALD R. GLAUB

Communication problems, which exist in any hospital, are multiplied in times of external disaster, the author states. He suggests the use of walkie-talkies as a means of effective internal communication and describes their use in a hospital disaster drill.

EVER SINCE the first conscientious hospital started preparations for handling an external disaster, communication breakdown has been a problem. A train wreck, a tornado or any other catastrophe involving a large number of casualties can flood a hospital emergency department swiftly and unexpectedly with individuals needing immediate medical attention. For this, to some extent at least, a hospital can prepare.

However, no amount of careful planning can avert the multitude of telephone calls that are certain to tie up the switchboard. Even in a disaster drill, where there are no hysterical phone calls, internal communication can present a problem.

The importance of this problem was demonstrated in two such drills at the University of Illinois Hospitals in Chicago. The experience during the first drill with busy interoffice telephones and an inadequate student messenger system pointed out the full effects of the communication problem and prompted the hospital administration to search for a solution.

USE OF WALKIE-TALKIES

It was at this point that the use of walkie-talkies—portable two-way radiophones—for internal communication was suggested. A second disaster drill proved the portable phones successful in maintaining a constant line of communication between the hospital control center and the key areas—casualty sorting, operating rooms and personnel and equipment pools.

The control center must know at all times what is taking place at key spots throughout the hospital. It is this nerve center which keeps the disaster teams functioning smoothly and effectively. But without constant communication with these areas, the medical director, who acts as disaster control officer, can only sit and wonder and piece together the fragments of information he receives from excited messengers.

During the first drill, the disaster control officer found himself relying on telephones that were usually busy and on messengers who could not be expected to know all the geography of the four buildings comprising the hospitals, or to recognize all faces and answer all questions. By using walkie-talkies, during the second drill, the control officer found himself in a different situation. He was always in contact with someone who could answer his questions, and the heads of key areas could always turn to him for answers to their own questions.

For example, the control officer was immediately aware of a large number of orthopedic casualties arriving in the triage area, and he was able to inform the equipment pool what equipment was needed on the orthopedic ward. In this case, however, there was no walkie-talkie on that particular ward, so he used a messenger.

Also, during the first drill, the control officer had to rely on written reports by clerical assistants in the triage area. This procedure caused a delay, which increased with each step in the disaster chain, because there could be no preparations by the ward areas in advance of the arrival of the patients.

Direct communication using the walkie-talkies brought more accurate information compared with the "second-hand" relays of the messengers.

EFFECTIVE COMMUNICATION

Part of the University of Illinois Hospitals' disaster plan included sending out a "roving expediter" who had a good working knowledge of the over-all plan. For him, the walkie-talkie not only cut down the amount of walking involved, but also increased the speed with which the control cen-

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The author wishes to acknowledge the help of Dr. Donald J. Caseley, medical director of University of Illinois Hospitals.

AN INTERN uses a walkie-talkie to report problems in his ward, while the roving expediter studies a casualty list before making his report to the control center.

ter could adjust operations to a turn of events anywhere in the hospitals. For example, knowing that a certain quantity of blood sent to the postoperative area was insufficient because the area was suddenly thronged with casualties, the expediter was able to radio the control center immediately.

Operations which were hampered by an equipment or personnel shortage were reported to the appropriate areas via the control center. When a high percentage of casualties in the triage area were of a certain classification, personnel and equipment were transferred from an area handling fewer casualties to the ward with the greater load. (But only the control center can order drastic changes in the disaster plan if any semblance of order is to be maintained.) With a premium on time, therefore, the expediter with a walkie-talkie was of incalculable value.

Walkie-talkies also help solve a frustrating problem in the operating rooms. Although not knowing what types of casualties are coming from the triage area, the surgical control officer must be able to gauge the priority of operative cases. His chief consideration is that there may be some patients in the sorting area who need surgery more urgently than those patients already in the waiting rooms.

Walkie-talkies enable the surgical staff to choose high priority casualties first. In other words, good communication permits the scrapping of the injudicious "first come, first served" procedure.

LIMITATIONS OF WALKIE-TALKIES

While the use of walkie-talkies solved most of the major communication problems involved in the second mock disaster, it was not an over-all solution. Walkie-talkies even presented a few minor defects of their own.

Among the unsolved problems were:

1. Some types of information should be in writing. These include orders for drugs, particular blood types and special equipment of a precise size or kind.

2. Only a few people can have access to the walkie-talkies, while others must rely on messengers.

3. Noise interferes with hearing the walkie-talkies.

4. Trained personnel are needed to handle the walkie-talkies.

Since the walkie-talkies are mechanical, they are not failure-free. Periodical checks and care to maintain the batteries make the walkie-talkies reliable to the extent that they facilitate coordination of the disaster plan by improving communication. However, total collapse of communication may result if a battery goes dead, a phone is dropped and damaged or a mechanical part fails to function.

Three of the portable phones were employed during the second drill. They were all tuned to the same frequency so that the two located in key areas could communicate with the one in the control center. Four or possibly five walkie-talkies can be used effectively on the same frequency. More than that, however, will result in typical "party line" confusion. During the drill, it was found that there was no interference with the three phones, and that they were effective as far away as two blocks. The only time the phones were difficult to use was when one of them was in a deep basement area.

Walkie-talkies might also be useful in the receiving lobby for relatives of casualties, in assisting with traffic control at the emergency entrance and in maintaining liaison with public information officers.

The University of Illinois Hospitals plan to keep relatives away from the physical facilities of the hospitals by receiving them in a building across the street. Messengers will be used to convey casualty lists to this information center. The hospitals also intend to explore the possibility of using a walkie-talkie to keep in contact with this center.

Solving the communication problem will not solve the problems of traffic control and handling of relatives and friends. But the relationship between communication and these problems is a direct one. As the control center's contact with the key areas falters (resulting in loss of control over the disaster situation), the other problems mount in number and intensity. Poor communication can result in clogging of the emergency entrance and sorting areas. Also, hysteria in the information center is another potential problem which can be stopped by effective communication.

Thus, walkie-talkies, while solving one of the greatest problems involved in handling an external disaster, also lend themselves to combatting other obstacles. ■

GOOD EMPLOYEE RELATIONS:

the feeling must be mutual

by LEONARD B. VISSER

Because the hospital offers a unique employee relations situation, the author states, it is a disservice to make suggestions for a hospital personnel program based upon the same patterns used for an industrial program. He offers instead some basic concepts which apply in any personnel relationship.

IN INDUSTRY, we have arrived at a basic realization that there are two products—the goods made and the people developed. One is no more important than the other because each depends upon the other.

Recognition by hospitals of the importance of personnel programs suggests recognition that the employees who perform the services are as vital a part of the picture as the patients who receive those services. Such a program, to be effective, is nothing more than recognition of the importance of people, communication with them, cooperation with them.

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This article is adapted from a presentation at an Ohio Hospital Association institute on personnel program planning.

One factor to be concerned about is the "organizing" problem.

If hospital employees were to demand an international union, it would not necessarily be a triumph for the union. It might instead be a pure and simple case of mismanagement, or the internal failure to provide the proper leadership and management. Employees usually want a union to represent their interests when management won't. What is really involved here is simply learning what people want, and then, *with them,* working out the means of obtaining these needs.

The firmest foundation for any company includes good pay, steady work, respect for the individual, the fullest possible participation by all employees and equitable sharing of the rewards of productive accomplishment. No labor union is constituted to seek more. However, the employee relations program of any specific industrial corporation would not apply to a hospital. It would be a disservice to offer hospitals a pattern to follow. Rather, it would be better to make suggestions not on patterns but on concepts, for these apply generally wherever people are dealing with people.

Whether hospitals know it or

not, there is an employee relations program in every hospital in the country. Whether it is charted or planned or even staffed is not the point. It is there, either as a functioning reality, or as a vacuum—by default.

Peter Drucker, one of America's most respected management consultants, puts something of this in his definition of the role of a manager:

"A manager develops people. Through the way he manages, he makes it easy or difficult for them to develop themselves. He directs people or misdirects them. He brings out what is in them or he stifles them. He strengthens integrity or he corrupts them. He trains them to stand upright and strong, or he deforms them—whether he knows it or not. He may do them well, or he may do them wretchedly. But he always does them."*

The point is true of personnel relations generally. Such relations may be done well or may be done wretchedly—but they are always done. Therefore, in outlining some suggested concepts for a hospital personnel program, the guide lines group themselves into several natural areas:

1. The importance of fulfilling employees' needs. This area does not envision some grandiose giveaway program. It envisions, instead, getting something—the full performance of everyone in the enterprise.

2. Organizing to fulfill the needs of the enterprise and its people.

3. The effect of leadership on motivation.

FULFILLING EMPLOYEES' NEEDS

When we talk about motivation, we are talking about meeting the needs of people in return for what they can contribute to help reach the goals of the organization. However, motivating people usually involves change—changing operations, changing behavior, changing attitudes.

Certainly, in the field of hospital administration, change is one of those symptoms which we may not always feel but which can surely lead to organic disorders. Skills have proliferated in the hospital, the sheer size of many institutions has been a profound change and economic factors have been crowding hospital schedules today.

These changes have not affected just the hospital administrator, but they affect everyone working in the hospital. Any industrial manager cannot afford the luxury of feeling that changes affect only himself. Every change is a problem involving people—not just sheets of paper or charts.

There are probably more conflicting opinions about people's attitude toward change than to any other concept. For example, it is said that "human nature never changes," and that "you can't change people." At the same time, all of us know of the tremendous boredom that stifles the lives of many people. I believe that individuals do not dislike change as such. They welcome it when they have reasonable assurance that the change will be for the better, and when the change will better meet their fundamental, individual and group needs. However, people *do* hate to make changes blindfolded, and they hate to lose things that they feel are good.

ATTITUDES TOWARD CHANGE

The attitudes toward change are caused by some very fundamental needs in all of us. Some of them include:

Self-expression. This gives the individual a chance to develop and demonstrate his strongest abilities and talents. In the hospital, for example, employee relations can mean retaining a sense of dedication—a sense that can easily be lost through inattention to the human motives that create it.

Motivation to meet these needs involves pride in work and a recognition of pride in work by management and fellow workers.

Desire for New Experience. This is the need to escape boredom—to do new and different things. In hospital administration, I can certainly imagine that the increase in specialization, the tremendous growth in staff and the compartmentalization of duties which efficiency often demands could set the stage for gross decreases in the wide range of experiences which once might have been a powerful safeguard against this difficulty.

This doesn't mean that all individuals in a plant or a hospital can or should have an exciting job that changes greatly from day to day. It does mean, however, that people have to know enough about what they're doing to appreciate its usefulness.

One worker once said to me: "I never know what new problems are going to turn up in the next skid of paper—or even in the next sheet."

Self-determination. This is the feeling of freedom an individual received when he has some choice in making changes. It is also the feeling that people have when they don't wish to have things changed without their knowledge, or when they don't like to be put into a position where they are made to appear out of step with the rest of the group.

Sometimes this is referred to as "resistance to change," but this, in itself, is a somewhat complicated thing. Everyone resists change in the sense of having his automobile smashed, but very few individuals would resist change if it offered an opportunity to get a better car free in a raffle.

Most individuals very definitely don't like to have their social patterns, or their behavior patterns changed without warning and without reasons which are obvious to them. Every manager has been surprised repeatedly by the violent reactions from his employees to what he felt was an obvious and desirable change.

Competition. In a free enterprise system, there is always a lot of talk about competition, but I wonder if we ever really think about what it means to motivate individuals. Perhaps one reason for this is that we don't pay enough attention to evaluating performance. One of the frequent questions employees ask the supervisor is "How am I doing?" This is a difficult question to answer, and yet, I think all of us must learn how to answer this question.

Economic Needs. Earning a living and receiving a paycheck have been purposely placed after the other needs. Although there isn't

*Drucker, Peter F. *Practice of Management.* New York, Harper & Brothers Publishers, 1954.

any doubt that pay is an extremely important thing in employees' lives, management should realize that it is a necessary, but not entirely sufficient, consequence of proper motivation.

Determination of economic motivation is, in large part, a balancing process. Management will have to decide the following:

1. How to compensate individuals in a given work group in proportion to their effective contribution.

2. How to insure various work groups in an entire operation with a commensurate reward for their contribution.

3. How to insure that the rates paid in organizations are equitable compared to other businesses or industries.

Perhaps the most serious problem in economic motivation is the allocation of compensation between direct pay and employee benefits and services. For example, is "X" per cent of a man's pay put into an insurance program a better or a poorer means of motivation than an equivalent amount put into his base pay?

ORGANIZING MOTIVATION

There are different ways to motivate employees so as to meet needs and avoid problems which arise when these needs are not met.

First, there is force. Management can use power and prestige, its right to hire and fire, to force people to do what it wants, regardless of whether or not this meets their needs.

Second, management can use paternalism, providing the things that it thinks employees need to satisfy their legitimate needs. Of course, it is hoped that out of the goodness of their hearts, employees will produce—out of love and gratitude rather than out of real need fulfillment.

A third way to motivate employees is by mutual means. This is the most difficult to accomplish but is the best method. In this method, the manager tries to create a climate in which he and the work group can cooperate through mutual participation and communication to satisfy the needs of the individual, the needs of each work group and the needs of the enterprise.

Already, the thread that ties all of these considerations together can be seen: Recognition that the problems of the people in an enterprise are mutual, that their best solutions will be mutual also and that the success of the entire undertaking depends solely on the successful development of ways to work and grow together.

PERSONNEL DEPARTMENT

The personnel department *is* the appropriate representative to speak on the behalf of all employees: To recognize employee needs, to interpret them in the light of overall company needs, to explain them to other employees if necessary and to provide every necessary means so that the individuals involved can participate as closely as possible in the eventual solution.

Grievances need not be considered a painful experience that should not come up. On the contrary, one of the highest responsibilities of a personnel program is making sure that every "gripe," imagined or real, is heard, evaluated and acted upon. If it is a real grievance, with real and solvable factors involved, the personnel department wants to solve it—perhaps even more than the person who brought it up. If it is imagined, there is still a responsibility toward the person who brought it up and toward all of those with whom he works.

Companies do not ordinarily solicit grievances. Many do their best, however, to assure a climate in which they will be heard, in which they may be and will be brought up without fear. The object is not to guarantee that every whim will be fulfilled. Far from it. It is to guarantee that it will be *heard*. What is done about it depends, case by case, on the full facts involved and upon the ultimate discretion that must be exercised on behalf of the entire enterprise.

The personnel function is not a luxury, not an administrative vermiform appendix. Instead, it is the alternate heartbeat of the entire industrial system. It is the employees who are to industry exactly what the machinery is to the product.

The hospital situation is a little different. By their very nature, hospitals are unable to profit from the labor saving machinery which keeps U.S. manufacturing industries so efficient. However, automation will never replace the nurse.

CONCLUSION

Would good personnel relations pay off as a tool for fighting wage increases? The answer is "no". They would pay off, instead, in providing an atmosphere in which wage problems could be discussed realistically, openly and with an awareness of the general welfare, rather than in an atmosphere of pressure, hostility and selfishness. They would not sweep these matters under a carpet. They would bring them out in the open to be understood.

Would good employee relations pay off as a weapon with which to fight any threatened organization of personnel? Again, the answer is "no". They would, instead, create an atmosphere in which outside intervention would be unnecessary. This is not combative; it is cooperative.

Would an employee relations program undermine management prerogatives? Happily, the answer is "no" also. An employee relations program which represents the mutual interests of everyone in the organization does not relieve the manager of a single responsibility. It gives him, instead, greater responsibilities for judgment, evaluation, planning and arbitration. It also gives him a clear channel to the greatest resource he has available in assuring the success of the enterprise—the skills, ideas and human resources of the individuals with and through whom he must work.

In the hospital field, individual solutions and paths will have to be found. But as long as they rely upon people for the performance of those services for which they were organized, hospitals cannot really ask if good personnel relations pay off. They can only run the risk of observing what happens in the absence of such relations. ■

YOUR PRESIDENT REPORTS

Frank S. Groner, president
American Hospital Association

A Salute to the AHA Staff

I HAVE a confession to make. Because for years I have been a member of the American Hospital Association and have served on its committees, councils and Board of Trustees, I thought I was rather thoroughly informed about the extent of its work at the staff level. But during the past year, as the Association's president-elect and this year as its president, I have visited the Chicago office periodically and have seen the day-to-day operations. After this period of exposure, I freely admit that I had no idea of the magnitude of the program carried out by the staff of the AHA. And, since headquarters doesn't "blow its horn", someone should do it!

It is the staff's responsibility to fulfill the will of Association membership as voiced by the House of Delegates and the Board of Trustees. This means activating policies established by the House and formulated by the Board of Trustees within the framework of those policies.

At a single meeting last spring, I recall that the Board took 162 actions. While some of them were negative, that is to say, the trustees voted against some recommendations of the Coordinating Council, most of them were positive—requiring implementation at staff level.

The AHA staff organization, which at this writing totals 193, is divided into eight departments—Department of Hospital Financing and Community Planning, Department of Government Services, Department of Professional Services, Department of Administrative Services, Department of Publications and Communications, Department of Research and Statistics, Department of Central Services, and Department of Fiscal Services. The first four are devoted to planning and development of Association programs, the others to operation and implementation of those programs.

The list of subjects of immediate and lasting concern to hospitals with which the staff daily deals lengthens as the services of hospitals expand and grow. If you walk through the building at 840 North Lake Shore Drive, you will see AHA personnel working on various phases of these programs and problems and many more: care of the chronically ill and the aged; hospital planning, construction and design; nursing and nurse education; labor and personnel relations; financing; prepayment; professional relations; dietetics; engineering; purchasing; medical records.

SINCE THE AHA works closely with more than 100 other organizations in the hospital and health field, you would see staff preparing agenda and materials for meetings with a number of these—for example, the U.S. Public Health Service, the American Medical Association, the National League for Nursing, etc. Others would be making arrangements for various meetings with our own membership, which are held at headquarters and throughout the country, and for institutes and workshops, of which approximately 45 are conducted annually throughout the United States and in Canada.

You would see manuals and periodicals being written, edited, and going into production, kits of library materials painstakingly prepared to fulfill specific requests for information, research being conducted by several people in the broad area of, say, salaries in hospitals, and research being conducted by one person in order to answer, in the most complete manner, the request or the question of an AHA member.

But you would not see the entire staff at headquarters. Eleven of the 193 are at our Washington (D.C.) Service Bureau keeping in close touch with all legislative matters pertinent to hospitals and keeping the field advised of trends and happenings on the Washington scene.

At most times a number of staff people are neither in Chicago nor in Washington. Known as the "traveling staff," they may be engaged in the Hospital Counseling Program, serving on the faculty at a state hospital association meeting, in consultation with individual hospitals, conducting an institute or workshop, manning the Association's education exhibit at health and hospital meetings, or as far away as Liberia, as was one staff member recently, working under the AHA's contract with the International Cooperation Administration.

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State survey sketches intern-resident picture

- U. S. medical school graduates prefer straight internships.
- An estimated 25 to 50 per cent of foreign medical school graduates may be unable to obtain internships or residencies under the revised requirements of the Educational Council for Foreign Medical Graduates (ECFMG).
- Hospitals not affiliated with medical schools are more dependent on foreign medical school graduates to fill their intern and resident openings.

These are some of the indications of a survey of intern and residency programs in the State of Massachusetts, which have some implication for all United States hospitals.

In making the survey, the Massachusetts Hospital Association endeavored to obtain full information about internship and residency programs and the incumbents in these positions among its member hospitals. Little has been known about the number and type of internships and residencies filled by graduates of United States medical schools compared with those of schools in other countries. The reason for the intensified interest in this subject is the predictable increasing shortage of foreign medical school graduates in house staff positions in this state. This shortage will be an effect of the present examination program of the ECFMG. It is estimated that 25 to 50 per cent of the foreign-trained graduates who may desire to obtain hospital appointments in the United States as interns or residents may be unable to satisfy this examining body. Many hospitals in this state will also be affected if this estimate is correct.

by MYRON ROSE

Because little was known about the number and type of intern and resident programs in Massachusetts, the state hospital association surveyed its member hospitals, according to the author. In this article, he reports some findings of the survey, and comments on their national significance.

The data for this study were obtained from replies to a questionnaire mailed by the MHA to its 169 member hospitals; 156 replied. Twelve of the 13 nonrespondents did not have house officers. The questionnaire requested information as of April 30, 1959, on the number and nature of internship and residency positions budgeted and filled and the methods used for coverage by hospitals without house officers.

The survey disclosed that 43 per cent of the participating hospitals offered some type of internship or residency program. Internship programs were offered in 22 per cent of the hospitals, usually in combination with a residency program as well. Residency programs were offered by 36 per cent of the hospitals, with more than half of these not having an internship program. Of those hospitals having programs 38 per cent offered both types of programs, compared to 50 per cent nationally.[1]

A total of 1664 physicians are serving on the house staffs of the 72 hospitals offering programs. The number of budgeted positions totaled 1770. Vacancies reported by the institutions totaled 106, or 6 per cent of the positions budgeted. The breakdown may be represented as follows:

Residents	1269
Interns	395
Total House Officers	1664

Virtually all the internship programs are approved by the Council on Medical Education and Hospitals of the American Medical Association. The picture was practically identical as far as residency programs were concerned. Virtually all the residency programs are approved by the Council.

The findings indicate that there is no significant numerical shortage of interns and residents in MHA hospitals. The number of internships reported unfilled was 6 per cent, compared to 17 per cent nationally. The occupancy rate (94 per cent) for residencies also compared favorably to the national figure (84 per cent).[1]

The apparent lack of any significant numerical shortage of in-

At the time this article was written Myron Rose was administrative resident, Beth Israel Hospital, Boston.

The author wishes to thank the council on professional practice of the Massachusetts Hospital Association and the medical care studies unit at the Beth Israel Hospital for their assistance.

Table 1—Type and number of internships offered and means by which positions are filled.

Means by which positions are filled	Total	Type of internship				
		Rotating	Med.	Surg.	Ped.	Path.
		Number of positions				
Total positions offered	420	227	105	58	22	8
Filled by matching program (NIMP)	230	58	94	54	19	5
Filled otherwise	13	5	3	—	3	2
Filled by non-U.S. graduates	152	141	8	2	—	1
Unfilled	25	23	—	2	—	—
	Per cent of total of each type of internship					
Total positions offered	100.0	100.0	100.0	100.0	100.0	100.0
Filled by matching program (NIMP)	54.8	25.6	89.5	93.1	86.4	62.5
Filled otherwise	3.1	2.2	2.9	—	13.6	25.0
Filled by non-U.S. graduates	36.2	62.1	7.6	3.4	—	12.5
Unfilled	6.0	10.1	—	3.4	—	—

terns and residents conceals the fact that many hospitals still have serious house staff problems. These difficulties are reflected in the extent to which they have been unsuccessful in attracting graduates of U.S. medical schools and have had to turn to graduates of foreign medical schools. The survey showed that there were 152 foreign-trained interns and 380 foreign-trained residents serving as house officers, which was 32 per cent of the total.

INTERNSHIP STATUS

Table 1 (see above) shows the number and nature of all the internship positions budgeted and filled in the state. Several figures deserve highlighting. Of the 420 internship positions offered, slightly more than half were rotating internships, one-fourth were straight internships in medicine and the rest were distributed in surgery, pediatrics and pathology. Foreign-trained graduates filled 36 per cent of the total internship positions offered. Of the 152 foreign graduates, almost all occupied rotating internships. In fact, foreign graduates occupied 62 per cent of all the rotating internships available. Only 11 foreign-trained graduates filled straight internship positions.

The occupancy rate for internships was found to be 94 per cent in this state, but the meaningful fact here is that 23 of the 25 vacant positions are rotating internships. This fact, plus the U.S. graduate's preference for the straight internship rather than the rotating one, seems to emphasize the trend to filling rotating internships with foreign-trained graduates.[2] Therefore, hospitals offering rotating internships may find it more difficult to attract graduates of U.S. medical schools than graduates of foreign medical schools.

The National Intern Matching Program (NIMP) filled 55 per cent of the total available internships in the state; it filled almost all the straight internship positions available, but only 25 per cent of the rotating internships. The results for the state as a whole compared very favorably with the nationwide statistics (see Table 2, this page).

RESIDENCY STATUS

Table 3 (see page 64) shows the number and nature of all the residency positions budgeted and filled in the state. Certain figures deserve emphasis. Of the 1350 positions budgeted, approximately 900 are in the fields of general surgery, internal medicine, psychiatry and pathology.

Foreign-trained graduates occupied 28 per cent of the residency positions available in the state. The per cent of the various types of residencies occupied by foreign

Table 2—Types and percentages of internships matched through the NIMP in 1959.

Type of Internship	Per cent Matched	
	U.S.	Mass.
Total internships matched	52.9	54.8
Rotating	49.2	25.6
Straight Medicine	86.9	89.5
Straight Surgery	72.9	93.1
Straight Pediatrics	57.9	86.4
Straight Pathology	60.3	62.5

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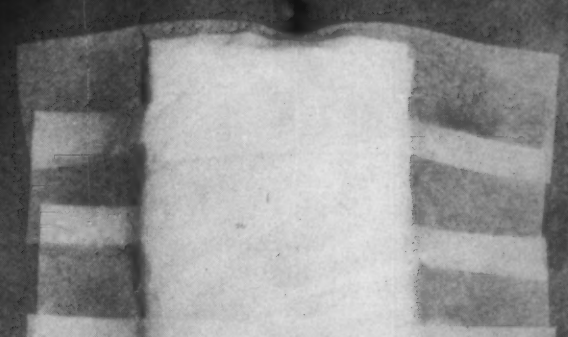

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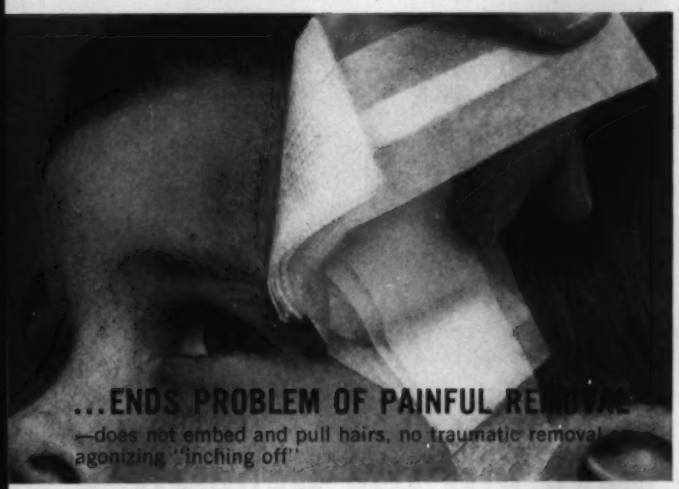

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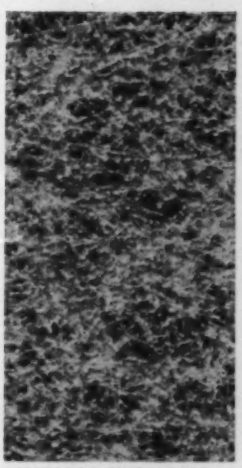

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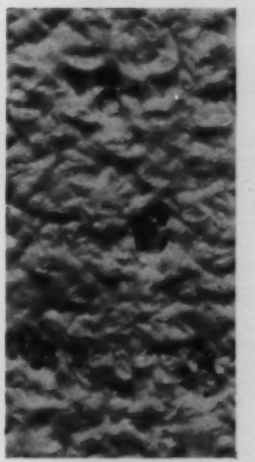

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Table 3—Type and number of residencies offered and filled by graduates of U.S. and foreign medical schools.

Type of residency	Number of positions				Per cent of total of each type of residency		
	Total offered	Filled by U.S. graduates	Filled by non-U.S. graduates	Unfilled	Filled by U.S. graduates	Filled by non-U.S. graduates	Unfilled
Total	1350	889	380	81	65.9	28.1	6.0
Medicine							
Internal medicine	242	180	60	2	74.4	24.8	.8
Dermatology	12	6	3	3	50.0	25.0	25.0
General practice	8	2	5	1	25.0	62.5	12.5
Neurology	26	15	4	7	57.7	15.4	26.9
Pediatrics	74	57	17	—	77.0	23.0	—
Pulmonary diseases	5	—	4	1	—	80.0	20.0
Surgery							
General surgery	314	235	70	9	74.8	22.3	2.9
Neuro-surgery	17	11	5	1	64.7	29.4	5.9
Oncological surgery	3	2	1	—	66.7	33.3	—
Ophthalmology	24	17	7	—	70.8	29.2	—
Orthopedic surgery	39	30	9	—	76.9	23.1	—
Otolaryngology	24	14	7	3	58.3	29.2	12.5
Pediatric surgery	1	—	1	—	—	100.0	—
Thoracic surgery	6	6	—	—	100.0	—	—
Urology	21	12	9	—	57.1	42.9	—
Obstetrics—Gynecology							
Obstetrics & Gynecology	43	36	6	1	83.7	14.0	2.3
Gynecology	6	4	2	—	66.7	33.3	—
Obstetrics	16	8	7	1	50.0	43.8	6.2
Other							
Anesthesiology	79	40	32	7	50.6	40.5	8.9
Pathology	117	49	55	13	41.9	47.0	11.1
Physical medicine	1	—	1	—	—	100.0	—
Psychiatry	207	126	49	32	60.9	23.7	15.5
Radiology	61	35	26	—	57.4	42.6	—
Stomatology	4	4	—	—	100.0	—	—

medical school graduates is close to the national average, after allowing for the specialty categories represented by small numbers. Foreign medical school graduates appear in relatively heavy proportions in pathology, radiology, anesthesiology and urology.

The specialties that accounted for the great bulk of the unfilled positions were psychiatry, pathology, general surgery, anesthesiology and neurology. In fact, 32 (40 per cent) of the 81 residencies reported unfilled were in psychiatry.

MEDICAL SCHOOL AFFILIATION

Most of the hospitals offering programs reported at least one non-U.S. graduate occupying some

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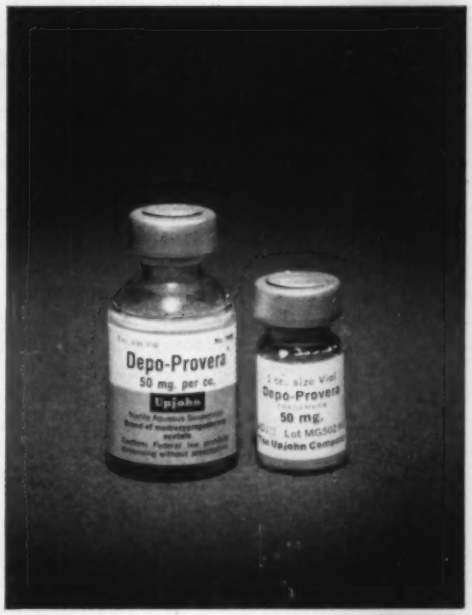

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position on its house staff, but the extent to which these hospitals depended on non-U.S. graduates varied greatly. The 16 hospitals with medical school affiliations had little difficulty filling their house staff complement with graduates of U.S. medical schools, but the nonaffiliated hospitals relied much more on foreign graduates to fill their house staff quotas.

The size or type of control of the hospital had relatively little bearing on its ability to attract U.S. graduates, compared to the factor of medical school affiliation. Both the larger and smaller nonteaching hospitals had to rely on non-U.S. graduates. For example, one hospital of 373 beds appointed 29 foreign-trained graduates out of a total of 37 positions budgeted; another of 150 beds had to appoint 12 foreign-trained graduates out of a total of 14 positions budgeted.

To fully appreciate the importance of medical school affiliation in attracting graduates of U.S. medical schools, let us consider the experiences of these two categories of hospitals with regard to internship. The 16 hospitals with medical school affiliations reported only 21 non-U.S. graduates out of a total complement of 226 interns. The nonaffiliated hospitals reported 131 foreign graduates out of a total complement of 194 interns. In other words, less than 10 per cent of the interns serving in the affiliated hospitals were non-U.S. graduates, but more than 67 per cent of those serving in the nonaffiliated hospitals were foreign graduates.

Illustrating the importance of medical school affiliation in attracting interns in general, teaching hospitals reported only two vacancies (one per cent) out of their 226 intern complement, compared with the 12 per cent vacancy rate in the nonteaching group. In addition, NIMP was also more effective in filling those positions available in the teaching hospitals. Almost 90 per cent of the positions available in affiliated hospitals were filled by NIMP, but only 20 per cent of positions available in nonaffiliated hospitals were filled by NIMP.

The significance of medical school affiliation with respect to residencies was almost as important. Affiliated hospitals appointed only 200 foreign graduates (23 per cent) out of a complement of 868 residents, but in nonaffiliated hospitals almost 38 per cent of the residents were non-U.S. graduates.

The medical school-affiliated hospitals reported an average per diem expense of $38.82, compared with an average per diem expense of approximately $32 in the nonaffiliated hospitals. This clearly indicates that a hospital does pay for the privilege of medical school affiliation—in the higher cost of daily operation.

These differences underscore the prime factor—teaching status—affecting a hospital's ability to attract a house staff composed of U.S. graduates. In general, institutions with these affiliations do well—those without them do poorly. The size of the hospital or its control appears to matter relatively little in the final analysis. Similar results were found in a survey conducted by the Hospital Council of Greater New York.[3]

NATIONALITIES OF HOUSE STAFF

Data have been provided by the Institute of International Education on the nationalities of non-U.S. graduates who served as house officers in Massachusetts hospitals during the 1958-1959 academic year.[4] These statistics showed that the leading source of foreign-graduates were the Philippine Island, representing approximately one-fifth of the total. The eight countries supplying the greatest number of foreign physicians, on a nation-wide basis, were the Philippine Islands, Turkey, Canada, Mexico, Iran, Korea, Greece and Japan. Nationally, the Asiatic countries accounted for slightly more than half the total, while in Massachusetts, excluding the Philippine Islands, the European countries had the biggest representation.[5]

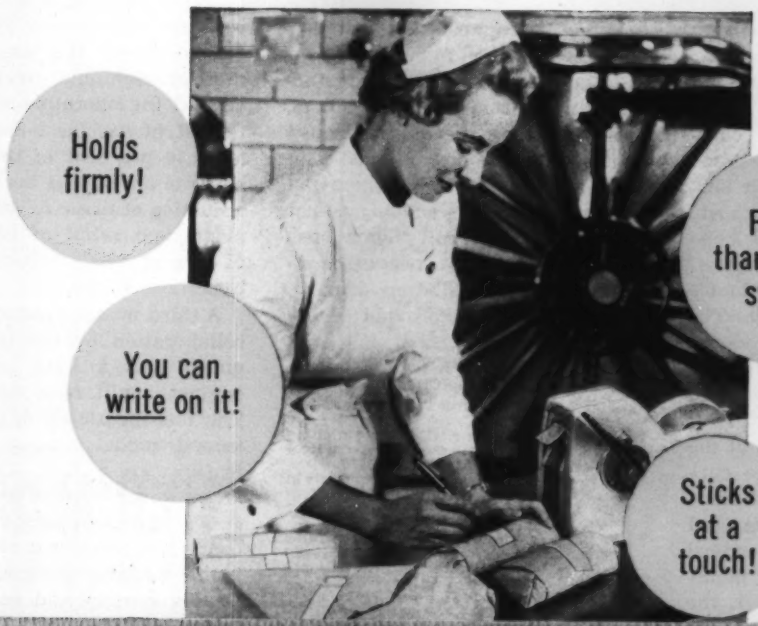
Although the assurance provided by ECFMG certification of foreign medical graduates will be appreciated by hospitals, and also by the public at large, it will reduce the number of foreign medical school graduates available to fill house staff positions in U.S. hospitals. In the examination given by the ECFMG in March 1960, 43 per cent of the foreign graduates taking the examination in U.S. centers failed to pass the test, while 49 per cent of those taking the examination in the overseas centers failed. A composite reduction of 46 per cent in the number of foreign graduates available to fill intern and residency positions would create a serious problem in many hospitals in this state, because it would mean a total loss of approximately 240 house officers.[6]

UTILIZATION OF EXTERNS

In order to alleviate this potential problem, the question was raised in this survey of introducing non-U.S. graduates who had not taken or passed the certifying examination as externs. In this status, such individuals could not participate in the care of patients except under the personal supervision of properly registered physicians who would be fully responsible for such patients. These externs could do physical examinations, take histories, do laboratory work-ups and make diagnoses that would have to be verified by the attending physician. The thought was expressed that suitable individuals could be used effectively in certain hospital situations. After a year's training, such men might then successfully pass the examination of the ECFMG and become available for full internship or residency.

The concensus of opinion was definitely unfavorable toward this idea. More than one-third of the hospitals indicated a positive disinterest, while only one-tenth indicated a positive interest. In fact, most of the individuals making additional comments on this subject implied that this plan would violate one of the very basic philosophies of the ECFMG.

Those hospitals without an approved intern or residency program were requested in the survey to describe how they obtained adequate medical coverage for their hospitals. More than one-fourth of these hospitals replied that members of their active medical staff rotated on call and more than one-tenth stated that they employed salaried physicians to give them full-time coverage. Approximately 40 per cent of the hospitals did not submit any information pertaining to this question. A variety of ar-



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rangements accounted for coverage in the other hospitals.

Occupancy rates for intern and residency programs offered in the hospitals in Massachusetts compare very favorably with nationwide rates, but the apparent lack of any significant numerical shortage of house officers tends to conceal the fact that some hospitals still have to depend on graduates of non-U.S. medical schools. The acuteness of this problem varied most specifically with whether or not the hospital had a medical school affiliation.

The examination program of the ECFMG will result in some curtailment in the number of non-U.S. graduates to fill house staff positions. Hospitals with medical school affiliations will still maintain their preferred status in the competition that will result for interns and residents. The loss will be felt mostly by non-affiliated hospitals that now rely considerably upon non-U.S. graduates for coverage.[7]

Nonaffiliated hospitals will experience increased difficulty in filling their quotas for house staff services and some other means of satisfying their needs for house staff will have to be employed. The trend may be toward having members of a hospital's active medical staff rotating on call. Some hospitals may find it necessary to employ salaried, full-time or part-time physicians to provide necessary services. ■

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NOTES AND COMMENT

Hospital-designed hypothermia unit

Hypothermia as an adjunctive therapeutic measure in critical illnesses has been employed in the Glynn-Brunswick Memorial Hospital, Brunswick, Ga., since early 1957. This technique, developed primarily for use in surgical procedures, has proven to be of equal value in medical cases, and is credited with life-saving properties in cases of record over a three-year period of use in this institution.

The first hypothermia unit, constructed by the hospital engineer from common refuse disposal cans, a centrifugal water pump, garden hose and a purchased hypothermia blanket and electronic rectal thermometer, was used in closed-heart surgical techniques. Later, this technique was combined with mechanical heart-lung bypass technique in open-heart cases, the first one being done in this hospital in December 1957. Since this time, all heart surgery has been performed using both hypothermia and the mechanical bypass technique.

The first hypothermia unit, although therapeutically adequate, was soon replaced by an improved model (see accompanying photo), which because of rapid, efficient heat exchange, ease of operation, and the fact that it made it possible to stabilize body temperature at a level of choice, was far superior to the initial unit. With this means of maintaining body temperature within one degree of a desired level, the use of hypothermic technique was extended beyond the operating suite.

Staff physicians believe that at least 50 per cent of these critical patients have lived because of the reduction of tissue oxygen requirements and relief of other effects of hyperpyrexia effected by the hypothermic therapy.

A third model, produced through collaboration by the hospital engineer and a local refrigeration engineer, will soon be available. The therapeutic advantages of the second model remain. Improved features are a more compact unit, an improved hypothermia blanket, easier operation and temperature control. A simplified switch, maximum heating control, maximum cooling control and an automatic heating-cooling control setting permit maintaining body temperatures at optimum levels with one degree tolerance. The unit will operate with water temperatures varying from 38° F. to 112° F.

Work toward further improvement is presently directed along lines of temperature drift scale computation to effect less overshooting in body temperature variation by the unit. This, of course, will necessarily vary with the case being treated—the height, weight, etc., of the patient.

Full diagrams of the heating-cooling unit's electrical circuits and operating instructions are furnished with each unit.—H. W. KILBY, *administrator, Glynn-Brunswick Memorial Hospital, Brunswick, Ga.* ■

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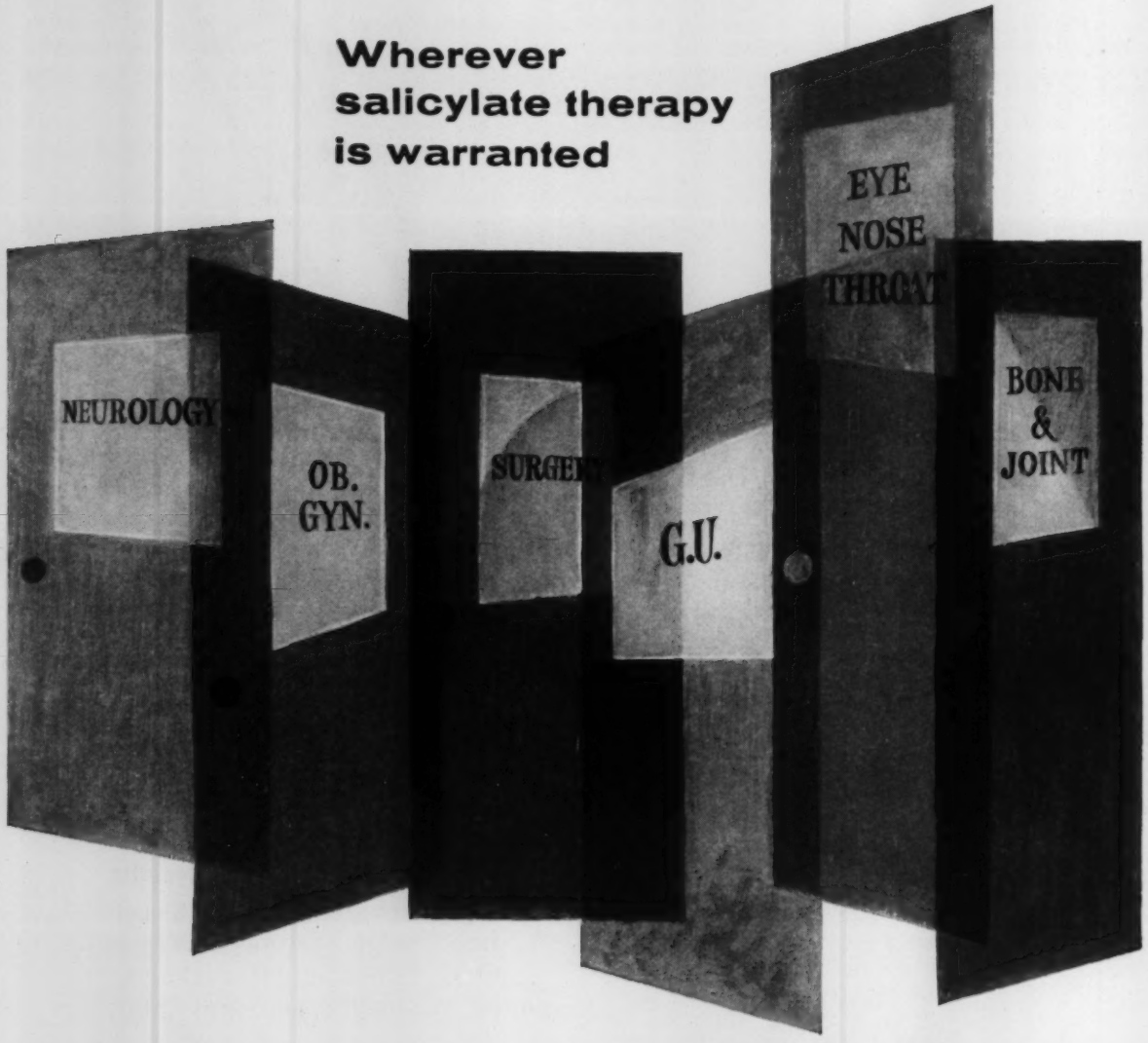

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How a pharmacy and therapeutics committee improves pharmacy service

by RUSSELL F. LOVELL

AFTER MORE than a decade of experience, the pharmacy and therapeutics committee of Akron City Hospital can point with satisfaction to accomplishments that have contributed directly to better care of patients and have benefited the entire medical and paramedicine staff. Among these accomplishments, are improved pharmaceutical service, insured quality of drugs and an orderly program of rational drug therapy.

Akron City Hospital is a private, nonprofit general institution of 519 beds and 85 bassinets. The annual volume of patients is large—1959 admissions were 18,178 and outpatient visits to the clinics totaled 17,034. The pharmacy department has approximately 4200 sq. ft. of floor space, which includes sterile solutions laboratories, a storeroom and a business office. The department is staffed by four registered pharmacists, two pharmacy externs, 11 full-time and 2 part-time auxiliary personnel.

When the pharmacy and therapeutics committee was appointed in 1948 to regulate and direct pharmacy activities, the inexperienced members of the committee had to pick their way carefully.

Russell F. Lovell is director of pharmacy service, Akron City Hospital, Akron, Ohio.

CHRONOLOGY OF AKRON CITY HOSPITAL P&T COMMITTEE

1948—A pharmacy committee was appointed, consisting of a urologist, a general practitioner and the chief pharmacist, with the latter as chairman. The committee prepared a formal statement of pharmacy policy and a standardization list.

1949—The standard drug list was expanded. The committee also instructed the nursing staff to chart medications by generic name, inserting the brand name in parentheses.

1950—Remaining pharmacological classes of drugs were incorporated into the standard drug list. This list and the policy statement were issued to all medical staff members to keep them up to date.

1953—The structure of the P&T committee was revised; an internist was appointed chairman and the chief pharmacist became the secretary.

1954—A revised standard antibiotic list was issued to the staff.

1955—The use of isopropyl instead of ethyl alcohol was recommended by the committee. The committee denied a request to use color coding as a secondary means of identification of drugs.

1957—The committee recommended that prescriptions for house-case patients to be discharged be limited to not more than a 14-day supply of any medication.

1959—The committee adopted the ASHP formulary as the official formulary of the hospital. The committee further revised the policy governing starting of intravenous solutions by nurses; adopted a new parenteral solutions chart, and recommended an automatic stop order for antibiotics and barbiturates.

Among the major benefits of pharmacy and therapeutics committee activities are improved pharmacy service, assured quality of drugs and more intelligent handling of drugs, according to the author. In this article, he reviews the accomplishments of one hospital's P&T committee over a 12-year period.

More than three months passed before the committee made any official recommendations. Its major decisions during the next 12 years are listed in the chronological table on this page.

Current issues before the committee are formulation of policy about the use of investigational drugs in the hospital and development of some means of protecting its pharmacists, who dispense drugs according to the formulary system, from criticism by outside agencies.

Major pharmacy and therapeutics committee policies are listed in the material headed "Akron City Hospital Pharmacy Committee Policies" following this article (see page 72). What have been some of the benefits of implementing these policies?

One major benefit, improved pharmaceutical service, includes faster service because a greater proportion of the medications prescribed by physicians are stocked in the pharmacy. Speedier delivery

to the patients results from this.

The stocking of the more commonly prescribed drugs is the direct effect of the use of the formulary system—that is, purchasing and stocking the drugs selected by the pharmacy and therapeutics committee and approved by the medical staff. Since the drugs stocked in the pharmacy have been selected by representatives of the medical staff, physicians tend to prescribe these drugs, rather than to prescribe others, which would not reach their patients as quickly, because they would have to be purchased on special order.

ASSURED QUALITY

Assured quality of drugs, another benefit, means that drugs stocked in the pharmacy are selected carefully as to quality and source. No preparation is purchased just because it is a possibly useful combination of ingredients with a "catchy" trade name. No product of secret composition is considered, nor is a preparation from a pharmaceutical manufacturer of dubious reliability. This policy has assisted busy physicians who can ill afford the time to investigate the various products.

More intelligent handling of drugs is a third benefit. Through the formulary system, the house staff and the nursing staff have become more familiar with the generic names of, and have acquired more pertinent information about, the drugs in use. In many instances they can avoid the necessity of mentally sorting through six or more trade names in an effort to specify the prescribed drug.

The elimination of some proprietary combinations, some duplications and some nonessential drugs from stock has contributed to better knowledge of drugs by reducing the over-all number of drugs and combinations in use. Preventing many of the constantly appearing newer combinations and duplications from cluttering both our shelves and our minds allows us to devote more time to gaining more knowledge of the drugs in the formulary.

How many items have been eliminated? What is the number of pharmaceuticals which would crowd our shelves if the formulary system were not in effect? A difficult, if not impossible, question to answer. A partial answer might be gained by comparing the inventory list of a hospital pharmacy operating with a formulary to that of a pharmacy operating without a formulary, or to the inventory of a modern retail pharmacy handling 400-500 prescriptions a day.

The committee has also furthered education pertaining to drugs and procedures by circulating a bulletin of pertinent information to the medical and nursing staffs.

By the establishment of a policy respecting the prescribing and dispensing of drugs for charitable clinic patients, the committee has helped in setting proper standards of patient care, in training of the house staff and in avoiding unnecessary misuse and waste of medications.

By formulating and implementating such policies as those concerning automatic stop orders, administration of intravenous solutions by registered nurses and emphasizing pharmacy service for the inpatient rather than the homegoing patient and outpatient, the committee has improved the quality of patient care.

Eliminating some of the duplications, needless combinations and nonessential drugs has increased consumption of those drugs in the formulary, which has permitted larger volume purchases with resulting economies.

One of the first and most dramatic effects of this reduction in number of items involved vitamins. Prior to vitamin standardization, bottles of vitamin tablets and capsules were removed from the shelves and placed in a continuous line on the counter. This line, which extended for six feet, included 27 different vitamin products. Thirteen of these were single vitamin preparations, such as thiamin hydrochloride, ascorbic acid and so forth, and 14 were various trade name preparations of the multiple vitamin and vitamin B complex type.

Following standardization, these 14 were reduced to five formulas of specified combinations and potencies. The trade name preparations of multiple vitamins (maintenance formulas) had cost the hospital from $1.85 to $2.50 and up per 100 tablets in lots of 1000 and 5000. The one multiple vitamin (maintenance) specified in the formulary has been purchased from at least two major pharmaceutical manufacturers, in lots of 50,000, for as low as 50 cents per 100. Although economy has by no means been the primary goal sought, nor the most important effect achieved, economy has been a very worthwhile benefit to the patient and to the hospital.

THE SUMMING UP

The sum of activities of the pharmacy committee is not great, perhaps, nor has progress been swift and sure at all times. Even today, many medication orders are written for trade name and multiple-ingredient products not stocked in the pharmacy. Daily, many such items are purchased, and the unit, as purchased, is charged directly to the patient. On the other hand, increasing numbers of orders are written for drugs by generic names. To a large extent, the P&T committee enjoys the cooperation and understanding of the medical staff relative to such policies as dispensing by generic name, avoiding duplication, limiting pharmacy inventory, purchasing competitively and so forth.

It would seem, too, that it enjoys their understanding of the efforts of the pharmacy to provide the best possible pharmaceutical service to their patients, whom we in the pharmacy department also consider "our" patients. Intelligent pharmaceutical service—as opposed to the vending-machine type—has gained for the pharmacy department also the confidence of the administration. It knows that its interests will be considered properly in all respects and that administration will be kept informed of all pertinent matters. ■

* * *

AKRON CITY HOSPITAL PHARMACY COMMITTEE POLICIES

Various policies regarding the prescribing and dispensing of drugs have been formulated by the pharmacy committee and approved by the medical executive committee over a period of years. These established policy statements are herewith restated and assembled under subject headings for pur-

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1. Benson, Margaret E.: **Am. J. Nursing** 57:1136, Sept., 1957. 2. Smylie, H. G.; Webster, C. U., and Bruce, M. L.: **Brit. M. J.** 2:606, Oct. 3, 1959. 3. Ayliffe, G. A. J.; Alder, V. G., and Gillespie, W. A.: **Lancet** 2:456, Sept. 26, 1959.

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General Policy

1. Chemicals, drugs and preparations of the USP, NF and NND are to be used whenever possible.

2. A proprietary name is not to be used if the same substance is available under a nonproprietary name.

3. Simple combination preparations are to be avoided whenever possible, and the separate medications from stock drugs are to be used.

4. Drugs of identical composition will be supplied according to the nonproprietary name regardless of the proprietary name prescribed unless special note is so made by the prescriber, such as "no other trade name", "trade name only" or some similar specific designation.

5. A drug not included in the standardized listing, or a proprietary name as specified in item 4, will be obtained in the nearest size or quantity available and will be charged as such to the patient without refund privilege.

6. Administered medications should be charted by official (labelled) name with proprietary (prescribed) name following in parentheses.

7. For proper safety of the patient, all drug containers are to be clearly labelled with generic (or descriptive) names or with identifiable proprietary names or both. For new drugs, or drugs not commercially available, and not obtained from the hospital pharmacy, the physician should make certain that proper information regarding the drug is available at the nursing station and the pharmacy.

Policy Regarding New Drugs, New Dosage Forms and Drugs Not Stocked in the Pharmacy.

1. Requests for a limited supply of new drug, or for dosage form to be available in the pharmacy for trial use, or for such item to be added to regular pharmacy stock, are to be submitted to the chief pharmacist for transmission to the pharmacy committee.

2. The application should include the name of the drug and the dosage form required, a statement as to whether the new drug is to replace a drug already in use and, if indicated, a statement describing the advantages of the new drug or dosage form.

3. When the trial supply is exhausted, a request in writing that the drug be listed in the formulary and stocked by the pharmacy should be made to the pharmacy committee. The request should include advantages of the new drug or dosage form, whether it is an addition or replacement; if a replacement, the formulary or stock item it is to replace.

Policy Regarding Drugs and Prescriptions for Clinic Cases.

1. Clinic prescriptions written for preparations not stocked in the pharmacy cannot be filled without permission of the pharmacy committee.

2. The physician prescribing a nonstock item is to be notified by the pharmacy so that he may write for an alternate stock item and, if he so wishes, submit application to the pharmacy committee for later use of the nonstandard preparation.

3. Such application should specify the name and the total amount of the item so desired, the ingredients and strengths, the supposed advantages and the case or cases for which the item is desired.

4. Except for emergencies, applications will be considered at monthly meetings of the committee.

5. Clinic prescriptions must be written with specific directions ("as directed" and "prn" are not sufficient).

6. The quantities dispensed on clinic prescriptions will be limited.

Policy Regarding Drugs and Prescriptions for House Cases.

1. The quantity of drug dispensed on house-case, home-going prescriptions shall be limited to not more than a 14-day supply.

2. Pharmacy may not make special purchase of drugs that are not stocked in the pharmacy for house cases until a new (or special purchase) drug application is completed by the physician. New drug applications for drugs not stocked in the pharmacy, when such items are ordered for a house case by the intern or resident, are to be countersigned by the chief resident. Pharmacy is to purchase the item on receipt of the countersigned application and forward a copy to the attending staff physician on that particular service. ■

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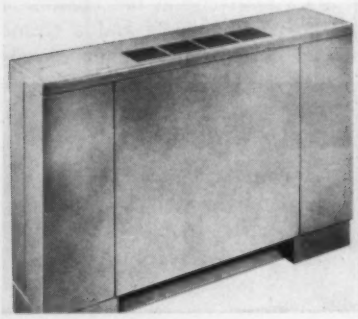
equipment and supply review

New product descriptions included in this section are condensed from reports furnished by manufacturers and distributors. Descriptions are included here for informational purposes and such inclusion does not constitute endorsement by the American Hospital Association.

Air conditioning unit (23E-1)

Manufacturer's description: Available in five sizes, this air conditioner helps maintain room temperature and humidity in hospitals with central hydronic cooling and heating systems. An 8½-in. width is provided in both the concealed models and cabinet styles which can be semi-



recessed up to 3¾ in. These models provide removable filters and motor-fan assemblies, three-speed push button control and optional accessories including grilles, drain pans, inlet plenums and aluminum wall boxes. *Bohn Aluminum & Brass Corp., Dept. H23, Danville Div., Danville, Ill.*

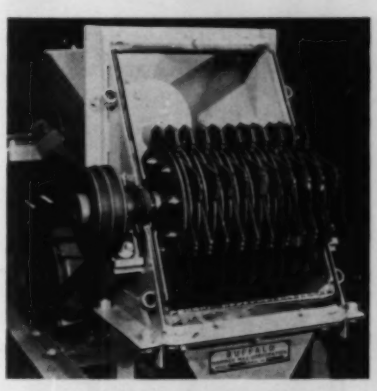
Thermometer sterilizer (23E-2)

Manufacturer's description: Used thermometers are dropped in an open-

ing in the cover of this stainless steel and glass container, which submerges it in the sterilizing chemical. When a fresh thermometer is required, a twist of the dial "pops up" a sterile thermometer that has been in the antiseptic for an adequate length of time. This simple device makes up to 11 thermometers available in rotation. The mechanism is designed so that the thermometers cannot be removed until they have been sterilized. *Osakis Industries, Inc., Dept. H23, Osakis, Minn.*

Disposal unit (23E-3)

Manufacturer's description: This automatic unit is constructed in a manner similar to heavy-duty hammer mills to take care of large amounts of waste food. Cabinet units are supplied with stainless steel tops in right or left hand assemblies, the grinder is enclosed and metal safety curtains help prevent kickback and prevent water spray from entering the grinding chamber. The mechanism will handle food wastes with the exception of ba-



nana stalks and corn husks; it will not handle solid materials, such as glass and metal. *Buffalo Hammer Mill Corp., Dept. H23, 1247 McKinley Pkwy., Buffalo 18.*

Maternity kit (23E-4)

Manufacturer's description: Included in this self-care maternity kit are six disposable underpads, 24 obstetrical pads, one box of textile cleaners and one snap-on sanitary belt. This self-care kit provides added service and convenience, and the patient who owns kit can keep the remaining pads and cleaners for

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PRODUCT NEWS

_____Air conditioning unit (23E-1)
_____Thermometer sterilizer (23E-2)
_____Disposal unit (23E-3)
_____Maternity kit (23E-4)
_____Basket liners (23E-5)
_____Telephone ringing signal (23E-6)
_____Hospital bed lamp (23E-7)
_____Scouring pads (23E-8)
_____Regional-perfusion device (23E-9)
_____Sterilizer control system (23E-10)
_____Receiver carrier for steam kettles (23E-11)

PRDUCT LITERATURE

_____Contract furniture (23EL-1)
_____Steam cooking (23EL-2)
_____Air filtering (23EL-3)
_____Surgical monitor (23EL-4)
_____Paper food service (23EL-5)
_____Surgical instruments (23EL-6)

NAME and TITLE _____

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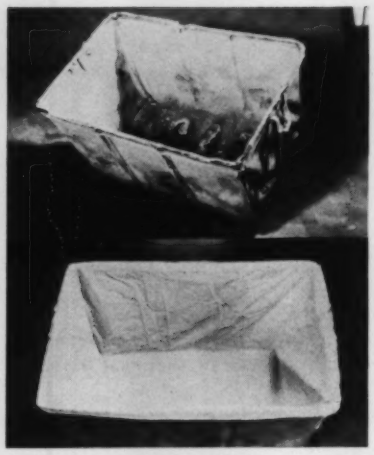
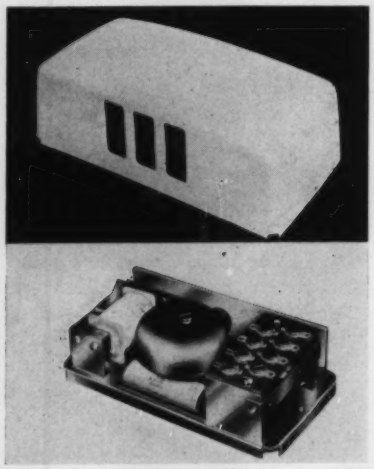
home care. *Will Ross, Inc., Dept. H23, 4285 N. Port Washington Rd., Milwaukee 12.*

Basket liners (23E-5)
Manufacturer's description: Available in white, red, green, blue or yellow and tailored to fit most standard laundry baskets, these 10-oz. combination industrial nylon and vinyl plastic liners may be snapped on or off with elastic rope. Ranging between 2 and 4 lbs., they will not absorb oils, greases or odors, and are unaffected by most acids and chemicals. *R. D. Bussard & Son, Dept. H23, E. 5th Ave., Albany, Ore.*



Telephone ringing signal (23E-6)
Manufacturer's description: Developed for use with compact telephones or as a replacement for existing ringers, this instrument emits a bell tone at the beginning of the ringing cycle and a chime at the end—repeated at three-sec. intervals. Suited for quiet hospital areas, this signal operates on straight line ringing, measures 3¼ in. x 5⅛ in. x 2 in. and weighs approximately one lb. Molded in plastic, the terminal block is self-contained, requires two screws for attachment, is available in all decorator colors and can be used for up to four party lines. *Wheelock Signals, Inc., Dept. H23, Long Branch, N.J.*



Hospital bed lamp (23E-7)
Manufacturer's description: Designed as a functional lighting unit, this UL approved hospital bed lamp pro-

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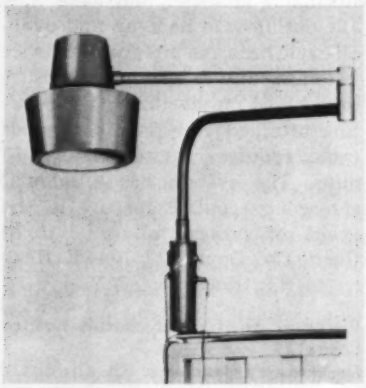
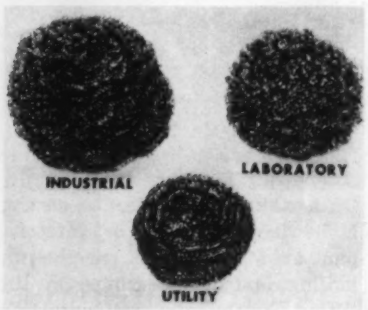
vides floor lamp features, yet is mounted in overbed frame sockets. It has a 3½-ft. horizontal reach with coil springs inside swivels that provide tension and prevent drifting. Provided with solid stops, the lamp is prevented from hitting walls. Double-walled, ventilated reflector swivels permit indirect lighting as well as correct reading light. A 7½-watt night light and plug-in receptacle are located in the control unit at the base of the lamp. A long pull chain on the



reading light switch facilitates patient control. *Adjustable Fixture Co., Dept. H23, 102-106 E. Mason, Milwaukee.*

Scouring pads (23E-8)

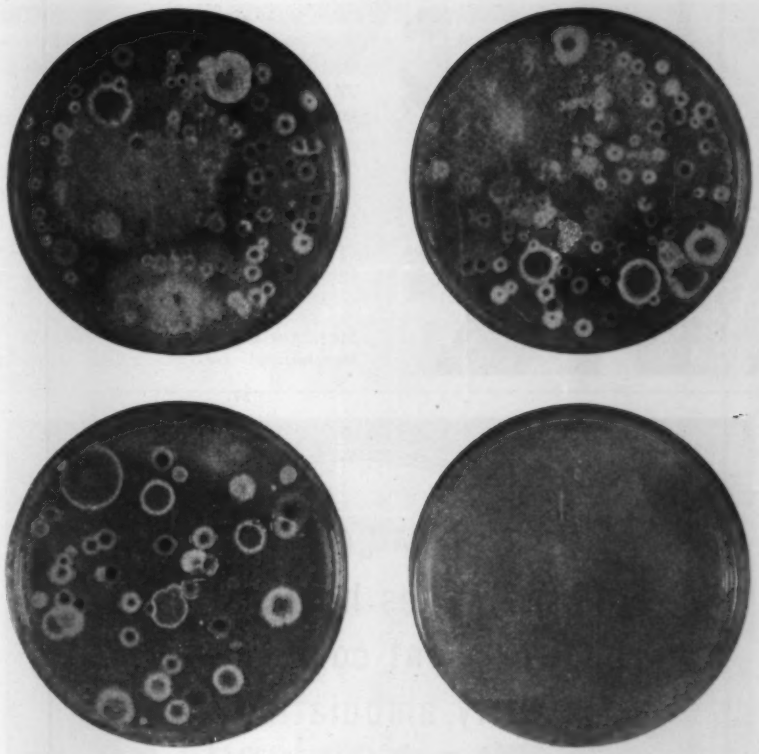
Manufacturer's description: These stainless steel scouring pads are available in three sizes, utility, laboratory and industrial. The soft but firm texture easily removes dirt, grime, discoloration and foreign matter without injury to the hands of the user. The pads are washable,



rustproof, durable and long lasting. *Terriss-Consolidated Industries, Dept. H23, 22 Wooster St., New York 13.*

Regional-perfusion device (23E-9)

Manufacturer's description: The disposable, plastic device shown in the upper left hand corner of the pic-



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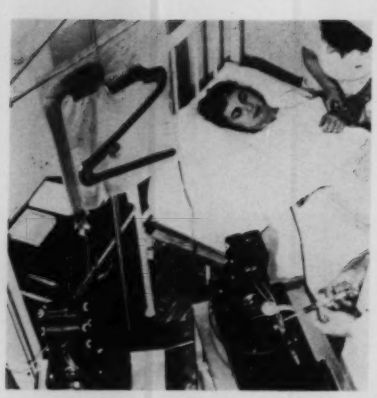


ture is to be used as an aid in treating certain cancers and infections through regional perfusion. This instrument helps make possible localized treatment with large doses of medication that previously were not used in such dosage for fear of damage to vital organs if the medicine entered the general blood circulation. *Baxter Laboratories, Inc., Dept H23, Morton Grove, Ill.*

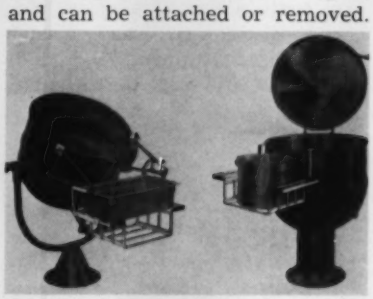
Sterilizer control system (23E-10)

Manufacturer's description: This system

employs an automatic high-vacuum pump to evacuate air from the sterilizing chamber and load, thus alleviating load heat-up and overall cycle time. An integrating device automatically determines exposure time based on sterilizing temperature attained. A typical dry-goods cycle requires approximately 15 mins. The system has a manual emergency control for use in the event of power failure. *Wilmot Castle Co., Dept. H23, 1944 E. Henrietta Rd., Rochester, N.Y.*

Receiver carrier for steam kettles (23E-11)

Manufacturer's description: To eliminate the spilling of food and all stooping, bending or lifting from the floor, these stainless steel receiver-carriers for steam kettles have been developed to hold stock pots and cafeteria pans for direct pouring or transfer of food from the kettles to pots or pans. The receiver-carriers fit any stationary or tilting kettle of 20 to 60 gals. and can be attached or removed.



On a stationary kettle, the carrier holds the stock pot or cafeteria pan at a convenient height for ladling and transferring. On the tilting kettle, the self-adjusting carrier holds a stock pot or cafeteria pan under the kettle spout as the pouring proceeds. The receiving container is never on the floor and never has to be lifted from such a spot. *The Cleveland Range Co., Dept. H23, 971 E. 63rd St., Cleveland 3.*

HemoVac provides positive and uninterrupted drainage starting immediately from time of closing incision. Keeps wound flat and free of inflammation, stitch cutting or irritation. Wound surface remains dry — dressing remains dry — sheets remain clean. Evacuator completely self-contained. All HemoVac parts are Low Cost—Disposable.

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Detach needle. Anchor tubing to skin.

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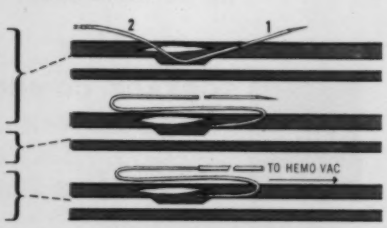

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product literature

SEE COUPON, PAGE 77

Contract furniture (23EL-1)—In this six-page color brochure, more than 50 illustrations of lightweight, metal contract furniture in the square tube and the round tubular upholstered steel frame design are featured. Also shown are seven color installations of this washable furniture. *The Howell Co., Dept. H23, St. Charles, Ill.*

Steam cooking (23EL-2)—This four-page illustrated catalogue has ideas and suggestions for selecting the steam unit that will suit the individual hospital's needs. *The Cleveland Range Co., Dept. H23, 971 E. 63rd St., Cleveland 3.*

Air filtering (23EL-3)—Illustrated in this folder is a system for keeping instruments and linens sterile for a longer period of time when exposed to the air in an operating room. *Surface Combustion, Dept. H23, Toledo 1.*

Surgical monitor (23EL-4)—Described in this booklet is an integrated electronic system for gathering, recording and displaying data on a patient's condition during and after surgery. *Epsco, Dept. H23, 275 Massachusetts Ave., Cambridge 39, Mass.*

Paper food service (23EL-5)—Included in this booklet is helpful information on most phases of food service. Also included are case histories and money-saving ideas that might be of practical value in hospital operations. Single copy price 25 cents. *Paper Cup and Container Institute, Inc., Dept. H23, 250 Park Ave., New York.*

Surgical instruments (23EL-6)—In the pages of this booklet are illustrated widely used instruments for stapes mobilization and related procedures. This booklet is representative and as complete as possible in relation to developments and refinements in the selection of instruments. *V Mueller & Co., Dept. H23, 330 Honore St., Chicago 12.*

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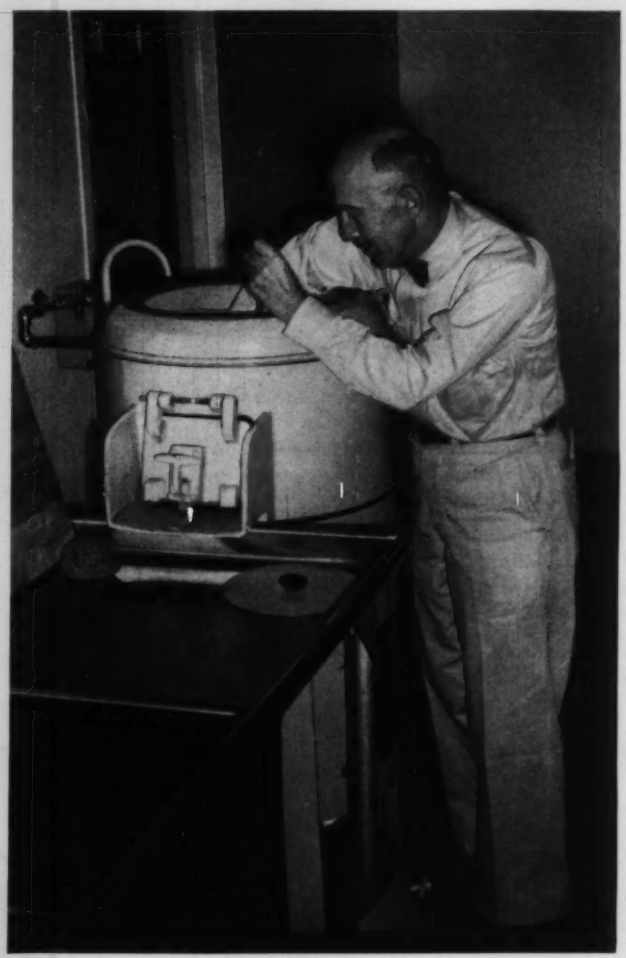
engineering and maintenance

ESSENTIAL INGREDIENT IN KITCHEN ROUTINE

--planned maintenance

by C. H. MATTINGLY



VEGETABLE peelers (shown in photo at left) require periodic checking and adjusting to insure proper performance.

MAINTENANCE OF kitchen equipment is a 24-hour chore because all the needed work cannot always be done during regular working hours, but it should be the goal of every engineer to keep all equipment in this department in top working order at all times. This discussion of the maintenance of kitchen equipment will follow the route of the food as it enters the building from the suppliers to the delivery of this same food to the patients, so far as this is possible to do.

The food and supplies enter the kitchen near the refrigerators and vegetable preparation area. The refrigerators should have regular and thorough inspection. The condensers usually need the most service, for if they are not kept clean, the units will overheat. The belts must be kept at the proper tension, and all moving parts should be regularly scheduled for lubrication.

The coils and fans in the refrigerators should be serviced frequently to prevent the accumulation of ice, and they should also be defrosted regularly. With this method, the temperature of the boxes does not change much. A close watch should be kept on the defrosting strip on the deep-freeze

C. H. Mattingly is superintendent of buildings and grounds, Presbyterian Intercommunity Hospital, Whittier, Calif.

This paper based on a presentation at the AHA Institute on Hospital Engineering, Los Angeles, July 1960.

Proper kitchen equipment maintenance is a difficult chore, the author admits, because it must be done largely during off hours and it involves much specialized equipment. In this article, he suggests guidelines to easier and more effective maintenance.

door, for if this does not function properly, the gasket may be torn from the door or frame, or both.

SERVICING THE DISPOSAL UNIT

The disposal unit at the vegetable preparation area is a source of trouble if not working properly. An abundance of water should flow through the disposal unit to prevent a clogged sewer; this means the solenoid should be checked often to see that it is opening all the way for a full flow of water. Some of the kitchen help may not be too particular about using the basket for the potato peels; sometimes it is not used at all. Then, again, it may be there, but is not emptied when it should be, so a sewer stoppage occurs.

Perhaps the cooking area is next in line. The ranges, especially if they are of the gas type, do not need much attention. The springs and latches on the oven doors are about the only parts that give any trouble. The same applies to electric ranges, except for the possibility of the elements burning out. A supply of these should be kept on hand, unless the hospital is in an area where these elements are serviced by a utility company, which will also render quick service.

Most kitchens have some steam cookers that operate on a direct steam line of 25-lb. pressure. The valves and traps on these cookers should be inspected daily. The safety mechanism on the doors needs close attention to prevent an accident due to opening the doors while the cooker still retains steam. The traps, valves and gaskets are about the only parts on the steam kettles that may develop trouble.

CHECKING EXHAUST HOODS

The hoods over the cooking areas can be a fire hazard if they do not receive the proper attention. Most hoods are equipped with filters to prevent an accumulation of grease in the duct system; these should be cleaned regularly. The length of time between cleanings depends on the type of cooking in a particular hospital. If large quantities of fried foods are cooked, the filters will need cleaning more often than those in a kitchen that does not prepare much fried food.

There should be a series of steam snuffers in the hood and ductwork leading to the outside, and the steam should be fed to these through a quick opening valve so that if there is a fire, it can be suppressed in the shortest possible time. It is a good policy to have some way of testing this quick opening valve other than by sending the steam through the snuffer nozzles. One way is to use a gate valve and bypass direct to the outside.

While on the subject of exhaust hoods, we should not forget the one over the dishwasher. The ductwork from this area should be inspected often, especially if there is a horizontal run after it leaves the dishwasher. The purpose of this ductwork and fan is to carry the excess steam to the outside. As this steam comes in contact with the outside air, it condenses and runs back, so if the joints in the horizontal run are not watertight, it will mean a repair job to refinish the ceiling over which it passes. When a new exhaust system is installed, it should be inspected carefully to see that all joints and seams are tight, thus preventing future repairs.

The mixers, food choppers and grinders can be a great source of trouble if not checked closely and often. If one of the knives of the food chopper has been nicked by accident, it will have to be ground enough to remove the nick. This throws the knives out of balance, so enough metal should be removed

A SIMPLE yet exacting task is getting the temperature-control mechanism of these small refrigeration units consisting of a fan, a coil and a compressor. (BELOW) The hospital engineer adjusts the booster heater on the dishwashing unit to increase the temperature of rinse water.

from the other knife to make them balance again. Without this balance, the machine will vibrate and more quickly ruin the bearings.

At least once each month, each of these machines should be inspected for lubrication, and to be sure there is not an accumulation of food particles around the moving parts. The engineer will do well to see that all wiring connections are tight and in good order. Of course, if the machine is direct-connected, there is not much of a problem in this area.

Some hospital kitchens have conveyor-type toasters, and these can be a real source of trouble if they are not kept clean. This trouble is common with both the gas and electric types. These should be inspected daily, and every six months these should be inspected thoroughly, or given a complete overhaul.

Waffle irons and griddles, mostly the electric type, have a way of causing trouble. This trouble often stems from the elements, and it is a wise engineer who carries a supply of these elements in his parts department. Ice cream cabinets and other small refrigerated units need the same care as larger refrigerators. Sometimes these units are serviced by the supplying companies, but the hospital engineer should check these to make sure everything is in proper order between service calls to avoid spoilage of the contents. If the units are water-cooled, these also should receive regular attention to see that all automatic valves are in proper working condition.

INSPECTING THE DISHWASHER

The dishwasher seems to need more service than any other item of equipment in the kitchen because it is more used and has more moving parts than any other item. Conveyor belts, pumps, sprays and soap injectors, and motors to propel all this mechanism, require constant attention.

Some dishwashers have baskets or racks in which to put the dishes to be washed. These alone are a great source of trouble. It is hard to keep them in proper repair, for they do get a bit of rough handling. Some are of wood-frame construction and others are all metal, but they become damaged just the same and need repairs often. Other dishwashers are not equipped with baskets because the conveyor is so made that the dishes are stacked directly on the conveyor to go through the prewash, wash and final rinse. Also, the canvas curtains at each end of the machine become worn and loose from heavy usage; these should be replaced when they begin to show wear.

It would be wise if the engineer made up a check list of the various items on the dishwasher that should be inspected. This could include: (1) daily inspection of all steam and water valves, both automatic and manual; (2) overflow and water drains; (3) canvas curtains, and (4) float valves for water levels in tanks, spray tubes and nozzles. A very important item is the temperature of the water for the prewash, wash, rinse and final spray. If the prewash is too hot, it tends to fuse some food particles to the dish, which are almost impossible to remove.

The engineer should also check the oil level of the gear reduction box and, of course, general lubrication. The couplings between the motors and the pumps should be watched closely, and also the packing on the pumps themselves, to prevent leakage. Conveyor belts and their driving mechanisms, including the clutch assembly, need regular attention. Also, the thermostatic controls should have close attention to insure a smooth running dishwasher.

The engineer should have sufficient repair parts on hand to carry him over in an emergency. A suggested parts list should include: belts, spare motors, impellers and spacer rings, curtains, valve discs, solenoid valves, thermometers, scrap traps and trays, overflow tubes, final spray nozzles and clutch assemblies. That may seem like a large stock of parts, but they are all necessary, and any one of them may be needed at anytime.

Another source of trouble are the detergent tanks and injectors; they also will bear watching. There should always be a grease trap in the sewer line from the dishwasher, and also from the pot sink. This is to keep an excessive quantity of grease out of the sewer lines to prevent a stoppage. It is necessary to keep this grease trap clean. Removing the lid from the trap makes for easy grease removal.

MAINTAINING CONVEYOR LINES

Some more modern kitchens use conveyors on their tray lines, and also employ them to convey the soiled dishes from the floors and the employees' cafeteria to the dishwashing area to be scraped and cleaned. These conveyors may be very simple or they can be very complicated.

In some kitchens, the food trays, after being assembled for the patients, are moved from conveyor line onto a subveyor to take to the various floors. This mechanism can become very complicated because the timing must be perfect. As the tray passes through the subveyor, it is lifted from the horizontal line and taken up. If the timing is off at all, a great deal of spilling occurs. The drive mechanism on this type of system must be kept in top condition at all times or the engineer will have a lot of trouble. This is a good system and a great time saver for the food service department, if it is always working properly—and this is the engineer's job.

When there is no vertical lift in connection with the conveyor belt on the tray line, good routine maintenance is all that is necessary to keep it operating in a satisfactory manner.

The food trays in most hospitals are transported to the patient area by means of tray carts. Some are the open-shelf type, others are the closed-cart type. Still others are of the closed type, but with a heated side and a chilled side for the different types of food. A chiller in a cart must be serviced much as small refrigerated boxes. The heating element also needs attention from time to time. The casters on the food carts need attention, such as removing strings and other debris that collect around the axles of the wheels. These carts should be taken to the maintenance shop on a regular schedule for inspection and lubrication. ■

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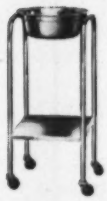

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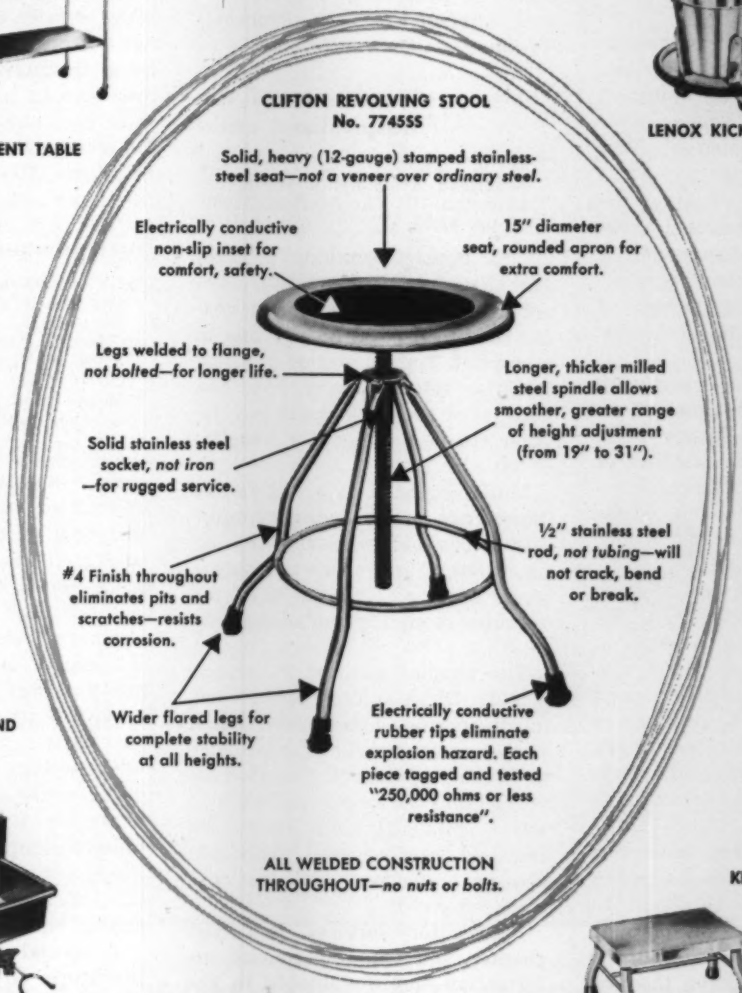
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book reviews

Best job in the world

also :
Total care of the hospitalized child
Nursing home operating costs

GREAT ADVENTURES IN NURSING, edited by Helen Wright and Samuel Rapport. New York, Harper, 1960. 288 pp. $3.50.

Personal glimpses of persons as diverse as Edith Cavell, Princess Ileana, Lillian Wald, an unknown medical corpsman and mother Bickerdyke are collected in *Great Adventures in Nursing.*

This anthology, spanning the past hundred years, has been carefully selected from documents by or about real people. Together, they form a striking mosaic of nursing anecdotes that tell what "nursing" means:

A pretty student nurse giving up her first big party because of an operating room emergency . . . the gallant nurses on horseback of Kentucky's Frontier Nursing Service . . . Father Damien whose service to lepers takes the reader back to 19th century Hawaii . . . the everyday work of visiting nurses in New York . . . the hardy Labrador nurse to whom an emergency call meant a 200-mile voyage through blizzards and stormy waters . . . Florence Nightingale, of course, and others, known and unknown, who have made a better nursing service possible.

A note of devotion, sometimes humorous, sometimes heroic, never overstated, sounds through the stories. A senior student, happy in her hospital experience, puts it simply: "I think I have the best job in the world."

With its grouping into hospital adventures, community service and adventures in war, this is a good book for the high school or public library; for student nurses, to whom it opens wide horizons, and for the varied members of the nursing care team, for they all have a place in the great adventure.

A later edition will no doubt correct a few typographical errors and omissions (e.g., the Cadet Nurse Corps is no longer in existence).—FLORENCE S. BURNS, *former director, Careers Program, National League for Nursing.*

Total care of the hospitalized child

CARE OF CHILDREN IN HOSPITALS. American Academy of Pediatrics. Evanston, Ill., The Academy, 1960. 96 pp. $1.50.

This booklet contains a great deal of useful information for anyone providing facilities for or giving care to a child of any age in a hospital. The chapter on physical facilities refers especially to the hospital of 100 to 200 beds, but the other chapters apply to a hospital of any size.

Much emphasis is given to the importance of surveying community needs before embarking on construction, and also to coordinated planning and the need for optimum flexibility and adaptability.

The chapter entitled "Communicable Disease Techniques" has much specific information which should prove beneficial, especially to nursing personnel. The chapter on meeting the emotional needs of the hospitalized child should be required reading for all people coming in contact with the hospitalized child.

"Laboratory services" is a short chapter, but contains concise information—more valuable to the generalist than to the specialist. The list of normal values for blood chemical analyses in children is an important addition.

The appendix contains some interesting sample forms which, again, are more helpful to the generalist than to the pediatric specialist.

This report is easy to read, as it is strictly narrative and contains very few figures. It is more of a discussion and less of a "standard".

Physicians with children in their care, public health workers, hospital administrators, and nursing, social service and dietary personnel will all profit by reading this book. Hospitals which admit children should have it available for their personnel to read.—HILDA H. KROEGER, M.D., *administrator, Elizabeth Steel Magee Hospital, Pittsburgh, Pa.*

Nursing home operating costs

COSTS OF OPERATING NURSING HOMES AND RELATED FACILITIES; AN ANNOTATED BIBLIOGRAPHY. Maurice E. Odoroff, Anna Mae Baney and Anne B. Stageman. Washington, Government Printing Office, 1960. 38 pp. 20 cents (U.S. Public Health Service Publication No. 754).

This bibliography provides a useful summary of the limited literature available on the cost of operating nursing homes and related facilities, which include nonprofit homes for the aged, public facilities and boarding homes. A summary table enables the reader to compare quickly cost information provided in all reports cited. Costs are given on a per resident day basis.

The writers caution that the material could not be compiled in a strictly uniform manner and, therefore, may not be comparable. They also note that the level of care provided varies considerably among the facilities included.

A special section abstracts the literature on accounting records for nursing homes and related facilities.

By carefully tabulating what information is available, the authors have provided a good basis for more comprehensive and methodical studies in the future. Given the limitations noted, this book should be of value to administrators and others considering planning and financing of facilities for long-term patients.

—BRYAN LOVELACE JR.

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personnel changes

LT. COMDR. BERGQUIST

● **Lt. Comdr. Melvin D. Bergquist, Jr.,** MSC, USN, has been appointed chief of the personnel and records division at the U.S. Naval Hospital, Philadelphia. He was formerly on the staff of the Naval School of Hospital Administration, National Naval Center, Bethesda, Md., as instructor in personnel management and chief of the personnel records branch.

● **Joseph G. Bertolami** has been appointed associate executive director of the first professional administrative services division of Jackson Memorial Hospital, Miami, Fla. Mr. Bertolami was formerly on the staff of that hospital between 1955 and 1958. He was then assistant to the director, Department of Hospitals, Metropolitan Dade County, Fla., and then administrator of Kendall Hospital, South Miami. He is a graduate of the Columbia University program in hospital administration.

● **Warren Edward Bishop** and **Francis James Murphy** have been appointed assistant directors of Genesee Hospital, Rochester, N.Y. Mr. Bishop holds a master's degree in public administration from Cornell University, Ithica, N.Y., and had been supervisor of nurses at McLean Hospital, Belmont, Mass.

Mr. Murphy graduated from the School of Public Health in Administrative Medicine, Columbia University, and then served his residency at Community Hospital, Glencoe, Long Island, N.Y.

● **Robert G. Black** has been appointed assistant to the director at Jackson Memorial Hospital, Miami, Fla., replacing **Garnett L. Radin.** Mrs. Radin resigned to accept the position of administrator of Shriners Hospital for Crippled Children, St. Louis.

Mr. Black is a graduate of the School of Hospital Administration, Medical College of Virginia, Richmond. For the past two years, while in service with the U.S. Army, he served as assistant adjutant at Walter Reed General Hospital, Washington, D.C.

● **C. M. Bogia Jr.** has been appointed administrator of Phoenixville (Penn.) Hospital, succeeding **Edward P. Street** who is retiring after 20 years in the hospital field. For the past six years Mr. Bogia was controller and assistant administrator. He was active in the establishment of the Philadelphia chapter of the American Association of Hospital Accountants and served as chapter president.

● **David D. Boyd** has been named administrator of Monadnock Community Hospital in Peterborough, N.H., replacing **Harold S. Fuller** who retired. Mr. Boyd was formerly on the administrative staff of Mary Hitchcock Memorial Hospital, Hanover, N.H. He is a graduate of the Yale University program in hospital administration.

● **Robert H. Brandow** has been appointed to the newly created position of assistant director of the Rochester (N.Y.) Regional Hospital Council. He was formerly assistant director of Aultman Hospital, Canton, Ohio. He is a graduate of the University of Rochester, and also of the Northwestern University program in hospital administration.

● **K. S. Bronstein** has been appointed administrator of Cedars of Lebanon Hospital, Los Angeles. He was formerly associate executive director of the professional administrative services department of Jackson Memorial Hospital, Miami, Fla. He is a member of the governing board of South Florida Hospital Council and chairman of the Hospital Division of Dade County (Fla.) Civil Defense Council.

● **Richard G. Burggraf** has been appointed administrator of Palo Verde Hospital, Blythe, Calif. He was formerly a consultant and also has served as assistant hospital administrator and manager of hospital business services at the University of California Hospitals, San Francisco.

● **Thomas L. Byram** has been appointed administrator of Bloomsburg (Pa.) Hospital. He was formerly assistant director of Hamot Hospital, Erie, Pa., for the past three years. Mr. Byram has a master's degree in hospital administration from Northwestern University.

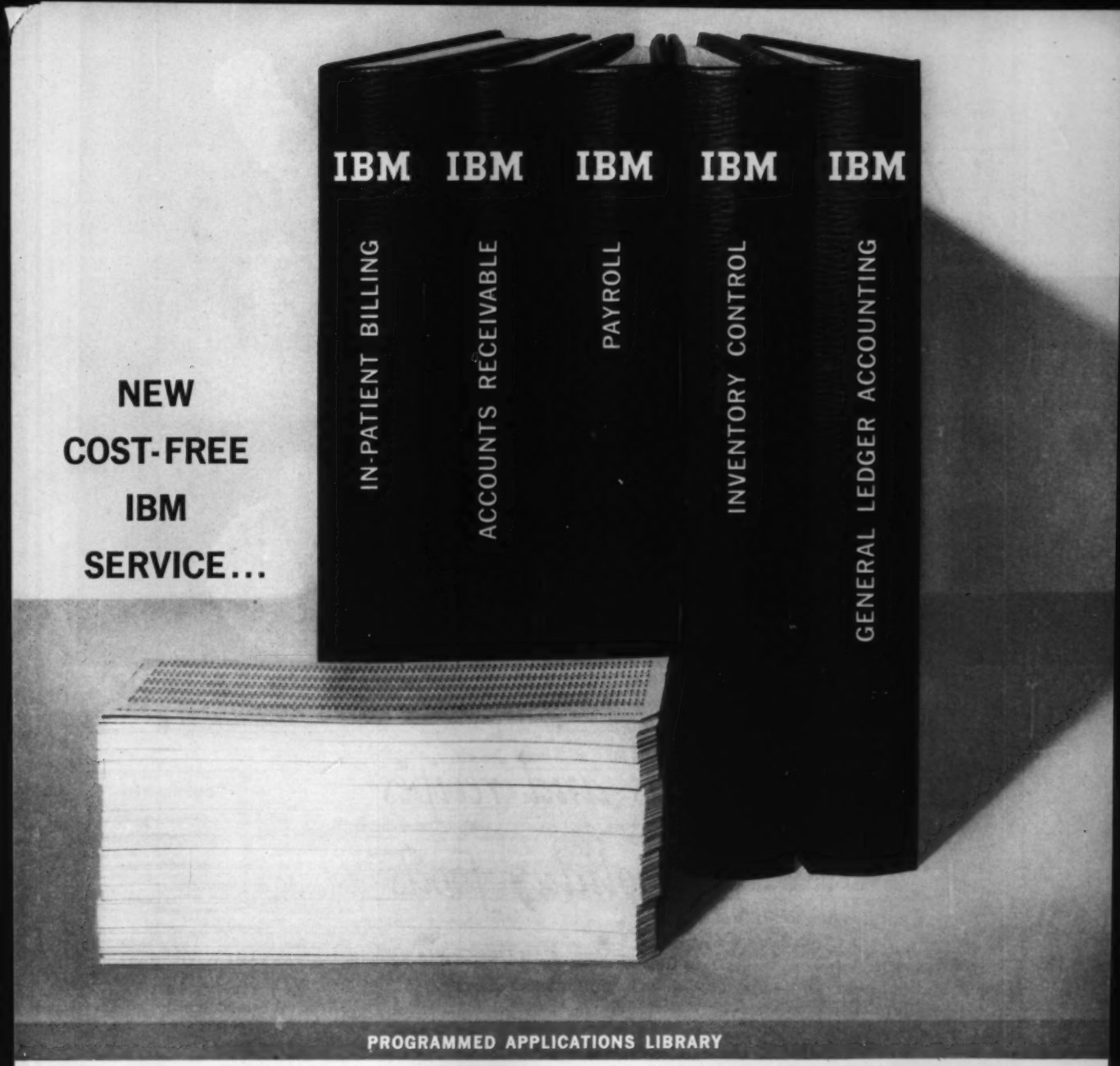
● **Earl D. Case** has been named assistant administrator of White Memorial Hospital, Los Angeles, Calif. He was formerly community relations officer for the department of development, College of Medical Evangelists, which owns and operates the hospital.

Mr. Case succeeds **J. Russell Shawver, R.N.,** who has been appointed administrator of Boulder (Colo.) Sanitarium and Hospital. Mr. Shawver is a graduate of the University of Chicago program in hospital administration.

● **John R. Coleman** is the new assistant director of the Administrative Services Division of Jackson Memorial Hospital, Miami. He joined the hospital staff after 28 years of army service. He spent 25 of these years in the area of hospital administration, more recently as administrator of U.S. Army hospitals at Ft. Gordon, Ga., and at Okinawa, Japan.

● **Ivan H. Corner Jr.** has been named administrator of Bozeman (Mont.) Deaconess Hospital. He was formerly with Doctors Hospital, Cleveland Heights, Ohio. Mr. Corner is a graduate of the Northwestern University program in hospital administration.

(Continued on page 109)



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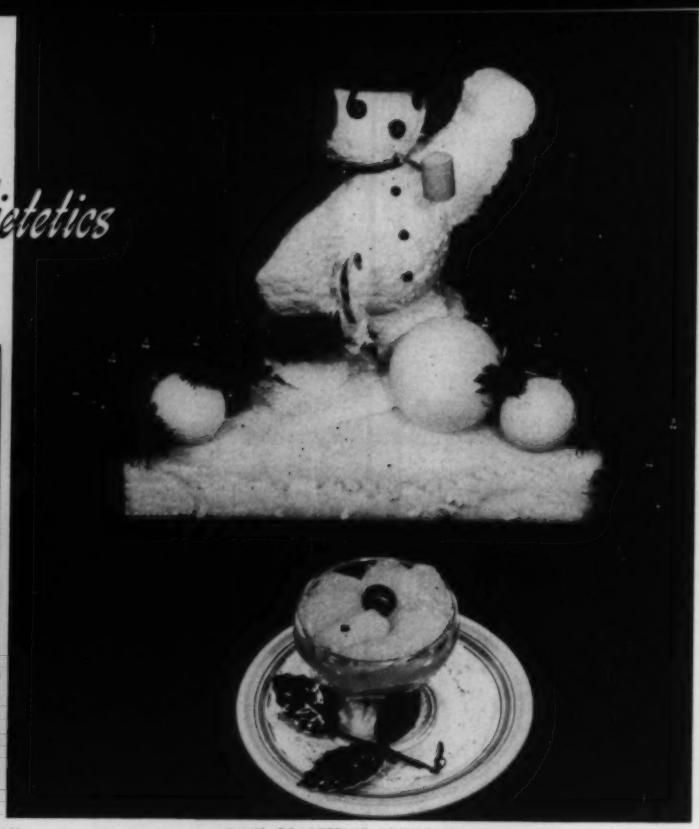

PINK GRAPEFRUIT SECTIONS

26 *menus and recipes for holiday foods*

IN THE SEARCH for something "new and different" in holiday food for hospital patients and personnel, it is reassuring to know that some menu or recipe that sounds interesting has been tried out in a hospital and has proved successful.

HOT TOMATO STARTER

The 8 selective menus for Christmas and New Year's Day on p. 91 and the 18 suggestions for holiday menu items, beginning below, bear this mark of success. There is a separate selective menu for the Midwest, South-Southwest, East and North-Northwest for each holiday. These selective menus and the recipes for the menu items were prepared by the authors of the AHA winter cycle menus, which were published in the October and November issues of this Journal. The selective menus are intended as menu inserts in the AHA winter cycle menu series.

The first of the 18 menu suggestions is hot tomato starter. Here is the recipe.

HOT TOMATO STARTER

(48, four-ounce servings)

1½ qts. condensed tomato soup
1½ qts. beef broth
1½ qts. water
2 tsp. marjoram
2 tsp. thyme
2 oz. butter

1. Combine all ingredients, except butter; simmer 2 minutes.
2. Dot mixture with butter.
3. Serve four ounces per serving. Use toasted saltines and parsley fluff garnish.
4. So that cracker will float, hold it by opposite sides close to soup and slip on top.

PINK GRAPEFRUIT SECTIONS

1. Section pinkmeat grapefruit.
2. Serve in sherbet glass and place a spray of artificial or fresh holly at stem of glass.

(Continued on page 92)

PLEASE CUT ALONG THIS LINE

CHRISTMAS DAY

	breakfast	noon	night
midwest	Half of Grapefruit (F) **or** Sliced Bananas (S) Cornflakes **or** Oatmeal Scrambled Eggs— Crisp Bacon *Pineapple Upside-down Biscuit	*Pineapple Wassail **or** *Hot Tomato Starter (FS) Roast Turkey (FS)—Cornbread Stuffing **or** Merry Roast of Beef Country Kitchen Cloverleaf Rolls Mashed Potatoes with Cream-Giblet Gravy (FS) **or** Au Jus Potatoes Green Beans with Almonds (F) **or** Buttered Tiny Whole Carrots (S) *Cinnamon Apple Cups **or** Cranberry-Orange Relish Salad Plum Pudding with Hard Sauce (F) **or** Lemon Custard (S)	Strawberry Frappe (F) Veal Birds (F) **or** Creamed Chipped Beef and Hard Cooked Egg on Toast (S) French Fried Potatoes (F) Buttered Succotash **or** English Peas (FS) Pear in Lime Gelatin **or** Mixed Green Salad with Blue Cheese Dressing Orange Sherbet with Sugar Cookies (FS) **or** Praline Chiffon Cake
south-southwest	Half of Pink Grapefruit with Green Cherry Garnish (F) **or** Frozen Orange Juice (S) Farina (FS) **or** Assorted Dry Cereal Scrambled Eggs **or** Poached Eggs Link Sausage **or** Crisp Bacon Christmas Sweet Bread —Currant Jelly	Christmas Consomme *Roast Turkey (FS)—Southern Cornbread Dressing—Giblet Gravy (F) **or** Roast Prime Ribs of Beef Au Jus Mashed Sweet Potatoes with Crushed Pineapple, Chopped Nuts and Marshmallows (F) **or** Buttered Rice (S) Dinner Rolls with Butter Buttered Green Beans (FS) **or** Buttered Whole Beets *Molded Cranberry Salad with Mayonnaise **or** Head Lettuce—1000 Island Dressing Eggnog Ice Cream and Christmas Cookies (FS) **or** Fruit Cup	Oyster Stew Baked Ham (F) **or** Macaroni and Cheese (S) Baked Potato (F) Buttered Frozen Mixed Vegetables **or** Buttered Asparagus Spears (FS) *Christmas Wreath Salad—Mayonnaise **or** Combination Salad—French Dressing Ambrosia (F) **or** Broiled Custard (S)
east	*Pink Grapefruit Sections (F) **or** Orange Juice (S) Oatmeal (FS) **or** Frosted Flake Cereal Scrambled Eggs— Crisp Bacon Christmas Stollen	Red Fruit Punch Broiled Steak, Watercress Garnish **or** Roast Turkey (FS), Chestnut Stuffing (F) Mashed Potatoes, Giblet Gravy (FS) Broccoli **or** Peas and Mushrooms (FS) Cranberry-Orange Relish-Peach Salad **or** Hearts of Celery, Olives *Mincemeat Tart Aglow (F) **or** Ice Cream Santas (S)	Consomme Vermicelli, Saltines Lamb Chop (FS)—Frosted Tokay Grapes **or** Cranburger Orange-Glazed Sweet Potatoes (F) Julienne Green Beans (FS), Sliced Almonds (F) **or** Whole Corn Kernels Cheese Stuffed Pear Salad **or** Tossed Salad, French Dressing *Holiday Cupcakes (FS) **or** *Raspberry-Lime Ice Compote, Macaroons
north-northwest	*Tinted Grapefruit with Cherry (F) **or** Frozen Orange Juice (S) Oatmeal **or** Puffed Rice Cereal Link Sausage **or** Scrambled Egg Christmas Stollen with Butter	Cranberry-Lime Cocktail—Crackers (FS) Roast Tom Turkey (FS)—Oyster Dressing (F) **or** Fillet Mingon with Mushrooms Mashed Potatoes (FS) with Giblet Gravy (F) Dinner Rolls with Butter Creamed Tiny Onions with Peas (F) **or** Julienne Carrots (S) *Molded Christmas Salad **or** Celery Cabbage with Blue Cheese Dressing Vanilla Ice Cream with Decorated Christmas Cookies (FS) **or** Frozen Fruit Cup	Oyster Stew with Oyster Crackers Baked Ham with Mustard (F) **or** Eggs a la Goldenrod on Rusk (S) Potato Puffs (F) Hubbard Squash with Lemon Butter **or** French-Cut Green Beans (FS) Stuffed Celery Salad **or** Placed Fruit Salad Pumpkin Custard with Turkey Cut-out of Cheese (FS) **or** Baked Apple

NEW YEAR'S DAY

	breakfast	noon	night
midwest	Orange Juice (FS) **or** Fruit Compote Blueberry Pancakes with Honey **or** Poached Eggs Smoked Sausage Links	Limeade (FS) **or** Creole Soup Baked Ham (FS) **or** Broiled Tenderloin Fillets Baked Potatoes (FS) with Sour Cream and Chives (F) **or** Candied Glazed Sweet Potatoes Southern Black-eyed Peas **or** Buttered Julienne Beets (FS) Molded Bing Cherry Salad **or** Creamy Cole Slaw Pumpkin Pie (F) **or** Chocolate Pudding a la Mode (S)	Raspberry Fruit Punch **or** Oyster Stew with Crackers (F) Cold Turkey Sandwiches with Pickle **or** Beef Fricassee (FS) Potato Chips **or** Buttered Noodles Broccoli with Lemon Butter **or** Baked Acorn Squash (FS) Frozen Fruit Salad **or** Lettuce Circles with 1000 Island Dressing *Orange Fluff Pie (FS) **or** Mincemeat Tarts
south-southwest	Frozen Strawberries (F) **or** Frozen Pineapple-Orange Juice (S) Oatmeal (FS) **or** Assorted Dry Cereal Scrambled Eggs **or** Poached Eggs Crisp Bacon Hot Biscuit—Honey	Beef Julienne Soup Roast Loin of Pork and Gravy (F) **or** Veal Cutlet (S) Whipped Potatoes (FS) Corn Muffins Frozen Black-eyed Peas (F) **or** Scalloped Squash (S) Sliced Tomato Salad—Mayonnaise **or** Slaw with Oil and Vinegar Dressing *Pecan Pie (F) **or** Whole Peeled Apricots in Syrup (S)	Cream of Celery Soup Broiled Chopped Steak with Mushrooms Au Jus (FS) **or** Broiled Chicken Parsleyed Buttered Potatoes (FS) Buttered Lima Beans **or** Buttered Sliced Carrots (FS) Combination Salad with Blue Cheese Dressing **or** Stuffed Pear Salad—Mayonnaise *Holiday Cake (F) **or** Assorted Gelatin Cubes with Whipped Cream (S)
east	Orange Juice (F) **or** Sliced Banana (S) Farina (FS) **or** Cornflakes Poached Egg— Grilled Sausage Links	Melon Fruit Cup Honey Glazed Ham (F) **or** Roast Stuffed Rock Cornish Hen (S) Duchess Sweet Potato (FS) Buttered Asparagus (FS) **or** Creamed Succotash Lettuce Wedge, French Dressing **or** Pineapple-Grated Cheese Salad *Eggnog Parfait Tarts (FS) **or** Plum Pudding	Consomme Royale Roast Sirloin of Beef, Gravy (FS) **or** Turkey a la King, Patty Shell Potato Gems (FS) Parsleyed Carrots (FS) **or** Mixed Garden Vegetables Assorted Relishes **or** Cranberry Salad Ice Cream Snowballs (S) **or** Brandied Fruit Cake (F)
north-northwest	Stewed Prunes **or** Fresh Frozen Orange Juice (FS) Farina (FS) **or** Bran Flake Cereal Soft Cooked Egg **or** Bacon Cinnamon Coffee Cake with Butter	Beef-Noodle Soup Prime Ribs of Beef (FS) **or** Grilled Loin Lamb Chops Steamed Potatoes with Gravy (FS) Frozen Buttered Mixed Vegetables **or** Buttered Asparagus Spears (FS) Grapefruit-Pomegranate Seed Salad **or** Tossed Salad with French Dressing *Cherry-Nut Refrigerator Dessert (F) **or** Raspberry Sherbet (S)	Tangy Tomato Juice with Wheat Wafer Oven Baked Chicken (FS) **or** Cold Ham Sandwich with Pickles Glazed Sweet Potatoes (FS) Buttered Green Beans (FS) **or** Scalloped Corn Cottage Cheese-Peach Salad **or** Cole Slaw with Green Grapes Fruit Cake (F) **or** Canned Pear Halves in Syrup (S)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

*Recipe and/or photograph of this item are included on pp. 90-99.

Midwest holiday menus were prepared by Mrs. Mary C. Zahasky, director, department of dietetics, and staff, University of Oklahoma Medical Center, Oklahoma City.

South-Southwest holiday menus were prepared by Roberta Foster, chief dietitian, Baptist Memorial Hospital, Memphis, Tenn.

East holiday menus were prepared by Carolyn Sebastianelli, chief dietitian, East Orange (N.J.) General Hospital.

North-Northwest holiday menus were prepared by Irma Nachtigal, head dietitian, Sioux Valley Hospital, Sioux Falls, S. Dak.

THIS PAGE HAS BEEN PERFORATED FOR EASY REMOVAL

MOLDED CRANBERRY SALAD

CINNAMON APPLE CUPS

PINEAPPLE WASSAIL

(1 gal.)

2 qts. unsweetened pineapple juice
24 oz. apricot nectar
1 qt. apple cider
1 pt. orange juice
12 in. cinnamon sticks, broken
2 tsp. whole cloves
8 cardamon seeds, crushed

1. Combine ingredients.
2. Heat to boiling; simmer 15-20 minutes.
3. Serve appetizer hot with lemon slice and clove garnish.

TINTED GRAPEFRUIT WITH CHERRY

1. Cut grapefruit in half and section each half.
2. Tint edge of rind with green food coloring.
3. Place green maraschino cherry in center.

SALADS

MOLDED CRANBERRY SALAD

(32 servings)

1½ lbs. (1 pkg.) raspberry flavored gelatin
¾ gal. boiling water
4 oranges
2 lbs. cranberries, washed and drained
2 lbs. sugar
2 tbsp. salt
1 qt. finely diced celery
1 qt. crushed pineapple
¼ c. lemon juice
1 lb. pecan pieces

1. Dissolve gelatin in boiling water. Chill.
2. Remove seeds and membranes from oranges. Grind or chop oranges and cranberries.
3. Stir in sugar, salt, celery, crushed pineapple, lemon juice and pecans. Add to chilled gelatin mixture.
4. Pour mixture into 12 by 20 inch pan. Chill until firm.
5. Cut 32 portions per pan.
6. Decorate each salad with mayonnaise or whipped cream.

Note: If staff and patient complement permit, salad may be chilled in individual molds.

CHRISTMAS WREATH SALAD

CHRISTMAS WREATH SALAD

(25 servings)

50 slices pineapple
3 c. chopped parsley
3 c. diced maraschino cherries
25 lettuce leaves

1. Arrange two slices of pineapple on each lettuce leaf.
2. Sprinkle chopped parsley and diced cherries on each pineapple ring.

CINNAMON APPLE CUPS

(45 servings)

1½ lbs. lemon flavored gelatin
1½ c. red cinnamon candies
6 c. boiling water
3 lbs. unsweetened applesauce
3 tbsp. lemon juice
Dash of salt
9 oz. cottage cheese, washed
1½ c. California walnuts, broken

1. Dissolve gelatin and cinnamon

(Continued on page 97)

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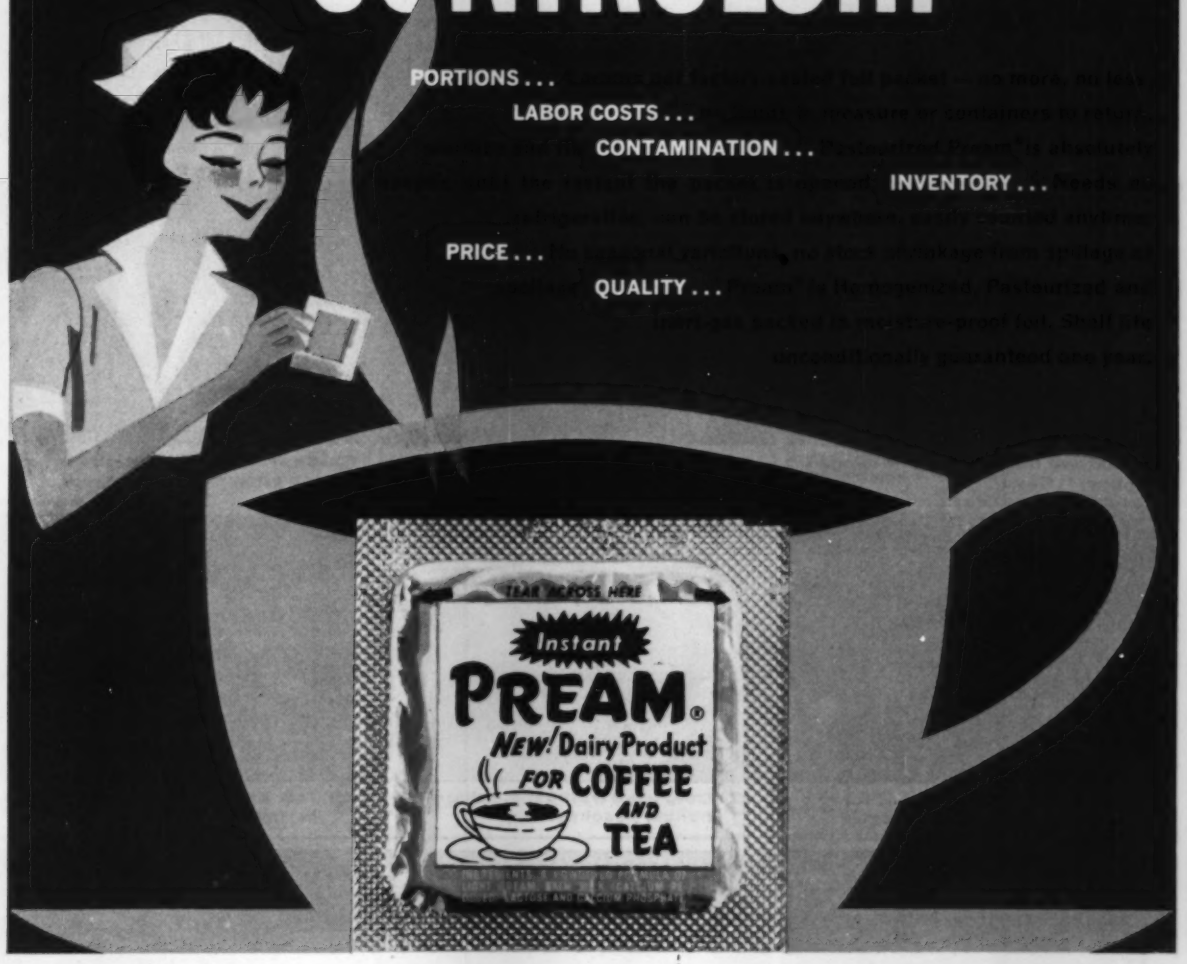

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1 **Extend ham loaf** with Kellogg's secret flavor.

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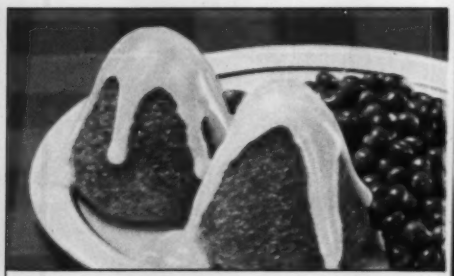
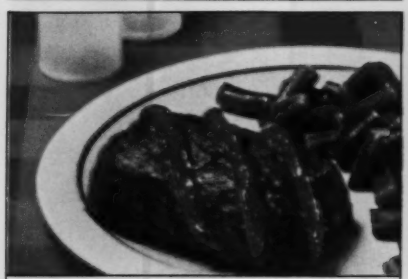
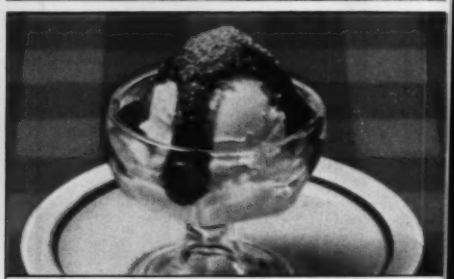


3 **Coat croquettes** with taste-tempting crunchiness.



4 **Extend individual meat loaves** and enhance taste appeal.

5 **Coat fried fruit**—apple rings, bananas, peaches.



6 **Top ice cream specialties**—parfaits, sundaes.

7 **French-toasted sandwich** coated with golden goodness.

8 **Crumb pork chops** to new golden goodness.

9 **Extend tuna casserole** and other casserole favorites.

10 **Sweet potato balls** rolled in crumbs.

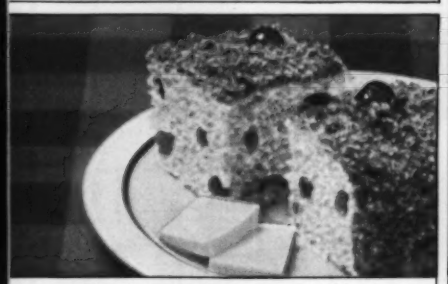
11 **Coat fried scallops** and other seafoods.

12 **Vary French toast recipes**—griddle cakes, waffles, too.

13 **Perk up stuffing** for turkeys, capons, ducks.

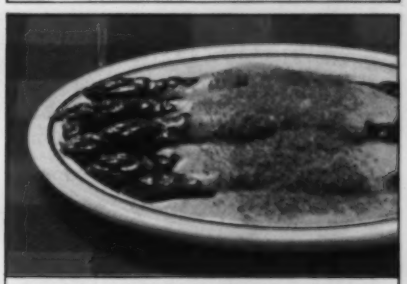
14 **Top baked macaroni** and spaghetti specialties.

15 **Top chocolate pudding** and other pudding desserts.



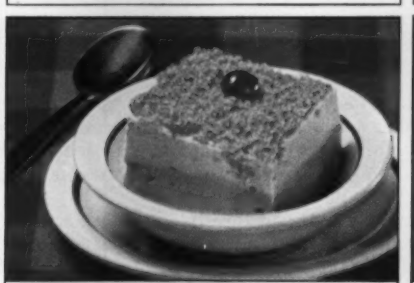
16 **Top coffeecakes** with crunchy crumb topping.

17 **Make chiffon piecrusts** light and surprising.

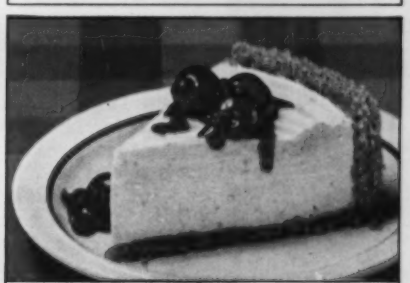


18 **Top creamed asparagus** and other vegetables.

19 **Cherry wink cookies.** Roll in crumbs before baking.



20 **Top refrigerated desserts**—custards, frozen crunches.



21 **Make better cheesecake** with crumb crusts, toppings.

Here you see a few uses for the most universal crumb of them all—new Kellogg's Corn Flake Crumbs. A creative chef can improve many a recipe by using these crisp, golden granules that go anywhere, do anything in the kitchen.

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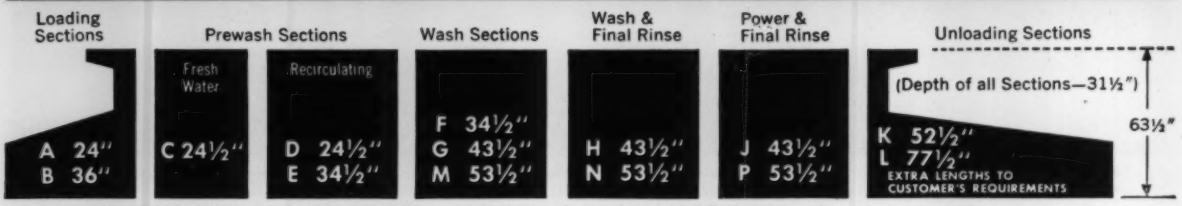

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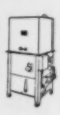

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candies in boiling water.

2. Stir in applesauce, lemon juice and salt.

3. Chill until partially set.

4. Wash the liquid off the cottage cheese; drain. Stir cheese and nuts into gelatin mixture.

5. Portion one-third cup of mixture into each individual mold or pour into refrigerator pans.

6. Chill until firm.

7. Unmold or cut 45 servings. Serve on lettuce leaf.

8. Decorate salads with cream cheese or mayonnaise in form of a star on top of each mold. Place a slice of stuffed green olive in center of star.

MOLDED CHRISTMAS SALAD

(24 servings)

12 oz. red gelatin
1 qt. pineapple juice
½ of No. 10 can pineapple tidbits, drained
2 lbs. cottage cheese, drained
12 oz. lime gelatin

1. Follow directions on package of red gelatin, except use 1 qt. juice drained from pineapple as part of the liquid.

2. Pour red gelatin and pineapple tidbits into 18 by 12 by 2 inch pan and let set until firm.

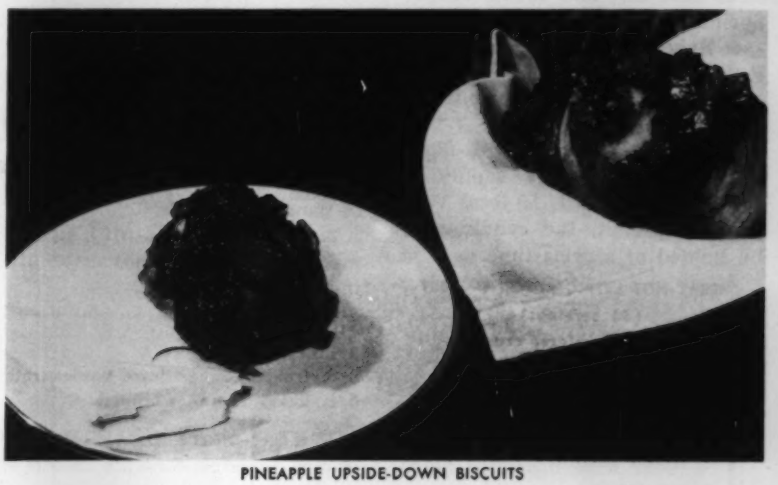
3. Spread drained cottage cheese over layer of red gelatin.

4. Pour lime gelatin that has been chilled to syrupy consistency over the layer of cottage cheese and chill until firm.

5. Cut 24 squares and serve on leaf lettuce. Decorate each salad with cream cheese which has been softened and put into pastry tube; place cream cheese on the molded squares to form a bow as if on a Christmas gift package.

MOLDED CHRISTMAS SALAD

ROAST TURKEY WITH SOUTHERN CORNBREAD DRESSING



PINEAPPLE UPSIDE-DOWN BISCUITS

ACCOMPANIMENTS

SOUTHERN CORNBREAD DRESSING

(50 servings)

1½ c. diced onions
2 c. chopped celery
¾ c. melted shortening
¾ gal. cornbread
½ gal. cubed bread
8 eggs, beaten
1 gal. chicken or turkey stock
1 tsp. black pepper
1 tbsp. salt

1. Sauté onions and celery in shortening until they are tender.

2. Add remaining ingredients.

3. Bake dressing in 12 by 20 inch pan for 1 hour and 20 minutes in 350° F. oven.

PINEAPPLE UPSIDE-DOWN BISCUITS

(50 biscuits)

50 biscuits
2½ c. crushed pineapple, drained
1¼ c. brown sugar
10 tbsp. butter, melted
2½ tsp. cinnamon
1¼ c. pineapple syrup

1. Prepare dough for 50 biscuits according to your own favorite recipe.

2. Combine all ingredients for topping.

3. Carefully grease the bottoms of 50 muffin pans to prevent sticking.

4. Spoon 1½ tbsp. of topping into each muffin mold. Top with biscuit dough.

5. Bake biscuits in 425° F. oven for 12-15 minutes.

6. Invert muffin pans immediately onto a clean surface. Cool

CHERRY-NUT REFRIGERATOR DESSERT

ORANGE FLUFF PIE

biscuits one minute before removing from pan.

MINCEMEAT TARTS AGLOW

(24 tarts)

7 c. canned mincemeat
8 c. chopped apples
2 tsp. grated lemon peel
8 tbsp. lemon juice
24, four-inch pastry-lined tart pans
Dough for top crusts for 24 tarts

1. Mix mincemeat with chopped apples, lemon peel and lemon juice.
2. Pour mixture into pastry-lined tart shells. Add top crust.
3. Cut opening in top crusts of tarts with tiny star cookie cutter. Sprinkle with sugar.
4. Bake tarts in hot oven (400° F.) 20-25 minutes. For a sparkling effect, bake tarts in foilware pans.
5. When tarts are cooled, place a small red birthday candle in center of each tart. If local regulations permit, the candle may be lighted at service time.

CHERRY-NUT REFRIGERATOR DESSERT

(50 servings)

2¼ lbs. vanilla wafers, crushed
18 eggs, separated
3 c. sugar
3 c. boiling water
1½ c. cherry juice
1½ c. lemon gelatin
1½ c. nut meats
3 c. maraschino cherries, drained

1. Line an 18½ by 12½ inch pan with half of the crushed vanilla wafers (1⅛ lbs.). Set aside.
2. Beat together egg yolks and sugar in top of double boiler. Add boiling water to make custard. Cook until creamy.
3. Take juice from drained cherries and add to lemon gelatin to soak. Then add hot custard and set aside to cool.
4. Beat egg whites until stiff. Fold into custard mixture.
5. Pour half of mixture into crumb-lined pan. Sprinkle with one-half of nut meats (¾ c.) and one half of chopped cherries (1½ c.).
6. Pour over remaining mixture; top with the additional nuts and cherries.
7. Set aside and chill until firm.
8. Cut 50 servings per pan. Garnish with whipped cream and maraschino cherries.

ORANGE FLUFF PIE

(3, nine-inch pies)

Crust

21 oz. vanilla wafer crumbs
13 oz. butter or margarine

1. Melt butter or margarine and combine with vanilla wafer crumbs. Portion 3 cups crumb mixture into each of 3, nine-inch pie pans. Press to bottoms and sides of pans.
2. Sprinkle remaining crumb mixture on top of pies after filling is added.

Filling

3 lbs. marshmallows
3 c. frozen orange juice concentrate
6 c. heavy cream, whipped

1. Heat marshmallows and orange juice concentrate in top of double boiler.
2. Stir occasionally until marshmallows melt.
3. Cool thoroughly.
4. Fold in whipped cream.
5. Dip mixture into pie shells (3¾ c. per pie). Sprinkle remaining crumbs from crust mixture on top of pies.
6. Chill until firm.
7. Cut eight servings per pie. Top each serving with an orange section.

Note: For display in the cafeteria or at special functions, individual pies may be decorated with a border of vanilla wafers cut in half. Orange sections may be arranged clockwise on top of pies.

PECAN PIE

(6, nine-inch pies)

2½ lbs. sugar
1 tbsp. salt
24 eggs, beaten
¾ lb. melted butter
1½ qts. dark corn syrup
1 oz. vanilla
1½ lbs. pecan halves

1. Mix sugar and salt.
2. Stir in beaten eggs and melted butter.
3. Blend in syrup, vanilla and pecans.
4. Pour mixture into 6, nine-inch, unbaked pie shells.
5. Bake in 400° F. oven for 1 hour or until knife inserted into middle of pie filling comes out clean.

EGGNOG PARFAIT TARTS

(25-30 tarts)

18 oz. lemon-flavored gelatin
1½ qts. hot water
3 qts. vanilla ice cream or 8 bricks
1½ tsp. nutmeg
4½ tsp. rum flavoring
1 doz. well beaten egg yolks
1 doz. stiffly beaten egg whites
25-30 baked pastry tart shells

1. Dissolve gelatin in hot water. Scoop ice cream or cut 8 bricks of ice cream into small pieces or scoops. Add to gelatin and stir until ice cream is melted.
2. Chill until partially set.
3. Add nutmeg and rum flavoring.
4. Stir in egg yolks; then fold in egg whites.
5. Pour mixture into tart shells; chill until set.
6. Top tarts with whipped cream

or whipped topping and a sprinkle of nutmeg, if desired.

RASPBERRY-LIME ICE COMPOTE

1. Scoop tiny balls of raspberry and lime ice (Christmas tree balls) and place in sherbet glasses.

2. Red-berried holly leaves placed at the base of the stemware makes an attractive holiday dessert.

HOLIDAY CAKE

(54 servings)

1½ lbs. special pastry shortening
3 oz. butter
3 lbs. granulated sugar
1½ oz. salt
1 lb. 5 oz. milk
2 lbs. 8 oz. cake flour
1 lb. 12 oz. frozen whole eggs
1 oz. pure vanilla

1. Cream shortening, butter and sugar in mixer at low speed for 5-8 minutes.

2. Add milk in two parts; emulsify well. Use second speed on mixer for 8 minutes.

3. Add sifted flour and salt. Mix until smooth.

4. Add eggs and vanilla gradually.

5. Mix for 5 minutes until batter is smooth and light.

6. Mix 6 oz. bread flour with 4½ lbs. crystallized cherries and 1½ lbs. nuts (pecan halves).

7. Pour 3 lbs. 7 oz. cake batter and 2 lbs. fruit and nut mixture into each of three, 10-inch lined steam pans.

8. Bake 1 hour and 20 minutes in 300° F. oven.

9. Cool at least 2½ hours or overnight.

HOLIDAY CAKE

HOLIDAY CUPCAKES

10. Cut 18 portions per pan.

Note: For pound cake, omit cherries and nuts.

HOLIDAY CUPCAKES

1. Prepare desired number of cupcakes according to your own favorite recipe.

2. Cool cupcakes and frost with boiled or foamy icing on top and sides so that cupcakes will be round.

3. One-half of the frosted cupcake may be sprinkled with white or tinted shredded coconut.

4. Place Christmas decorations (which are on sticks) in center of each cupcake. These decorations may be obtained at most dime or stationery stores in assorted packs of 6 or 12, and at bakery supply houses in boxes of one gross. ■

ADA Convention in Review

Dietitians examine their management role and skills and learn of widening horizons for their services

AT RECENT annual meetings of the American Dietetic Association dietitians have expressed concern over the emergence of food service managers, contract food services—and even well trained food service supervisors—as directors of hospital departments of dietetics. At this year's annual meeting in Cleveland in mid-October, the dietitians approached the issue in this way: How can we become better managers?

The key to better dietary man-

agement is being able to delegate responsibility and the authority that goes with it, Irvin L. Heckmann Jr., Ph.D., told the dietitians. Dr. Heckmann is associate professor of management, department of management, College of Commerce and Business Administration, University of Illinois, Urbana.

Dr. Heckmann approached the problem of delegation by first pointing out the values that accrue to the manager who learns to delegate. These plus-factors are:

1. Better employee morale with less turnover, absenteeism, tardiness and fewer employee grievances.

2. Employees grow on the job and develop to the point where they can, and want to, assume more responsibility.

3. Managers have more time to take care of their managerial responsibilities.

Dr. Heckmann's four-point program for effective delegation of responsibility includes:

1. Define thoroughly the work that is to be done.

2. Determine standards of performance so that the employee knows his goals and the manager has a measuring tool by which to gauge an employee's performance.

3. Recruit and select persons who are capable of assuming responsibility.

4. Communicate to subordinates what the work is and what standards of performance are expected of him.

Dr. Heckmann further advised dietitians to delegate responsibility as far down as possible in the organization, to give authority commensurate with responsibility, and to delegate everything that is routine.

MANAGEMENT APPRAISAL

Two physicians took the "better management" theme one step further and tackled the question: "Are hospital departments of dietetics measuring up? Kenneth B. Babcock, M.D., director of the Joint Commission on Accreditation of Hospitals, Chicago, said he believes that "they measure up pretty well, but there is still much that can be done to improve dietary care." He warned dietitians that the "zenith of hospital and medical care can be wrecked by cold coffee and cold toast."

Dr. Babcock also outlined the role of the department of dietetics in "making or breaking" accreditation for a hospital. He said physical aspects of the department of dietetics that JCAH surveyors look for include:

1. Clean, greaseless floors.

2. Hoods over stoves.

3. Female hygiene, such as the wearing of hair nets by food preparation and serving personnel.

4. Separate handwashing facilities for employees (not the multipurpose vegetable preparation sink).

5. Clean aprons on personnel.

6. Dishwashing facilities that have proper temperature controls (160-180° F.).

7. Refrigerators with thermometers and crash bars on the walk-in type. Unless proper drainage is provided in the floor, Dr. Babcock said, leakage points become "cesspools for hospital infection".

8. Disposal of garbage in a refrigerated, closed-in garbage room or by means of automatic disposers.

9. Filters on fan.

10. Clean filters on air conditioning equipment so that staphylococcal and streptococcal infections are not recirculated through the kitchen.

11. Regular schedule for cleaning of ice bins.

JCAH surveyors also check to see if there are written job specifications for all dietary personnel. The Joint Commission recommends that a member of the American Dietetic Association be in charge of the department of dietetics.

The second physician, Albert W. Snoke, M.D., past president of the American Hospital Association and director of the Grace-New Haven (Conn.) Community Hospital, took the physician to task for the so-called "poor medical staff-dietary relationship". Dr. Snoke said it is not the dietitian's inability but rather the physician's lack of knowledge that causes a breakdown in communication between dietitian and physician. He called on hospital administrators to ally the dietitian more closely with the medical team by providing for her participation at weekly department head meetings, at medical board meetings and at intra-hospital meetings for improvement of the care of the patient.

DIETARY SERVICE FOR AGED

In addition to finding themselves with a full-time management job based on their present responsibilities, dietitians heard numerous speakers direct their attention to an ever-widening field for dietary service—the aged and their nutritional care in the home, nursing home, retirement village and hospital.

Joseph H. Gerber, M.D., director of the Center for Aging Research at the National Institutes of Health, prescribed guide lines for dietary programing for the aged:

1. Restrict the individual's fat intake to 30 per cent of his total caloric intake.

2. Maintain the individual's body weight just below the level recommended in the National Research Council *Recommended Dietary Allowances.*

3. Plan his protein intake on the basis of 2 gms. of protein per kilogram of body weight.

4. Provide vitamin and mineral supplements (particularly calcium and iron).

Geraldine M. Piper, nutrition consultant for the chronic disease program, Public Health Service Division of Special Health Service, defined the role of the dietitian in the organized home care program. As Miss Piper sees it, the dietitian in an organized home care program, in addition to her direct therapy role through diet, will:

1. Participate in the advance planning for home care programs as well as serve as a member of the admission planning conference held as each patient is admitted.

2. Stimulate and arrange for conferences with nurses, physicians, social workers, etc.

3. Participate in periodic review conferences on patients in order that she may alter the patient's diet in accordance with his changing needs.

4. Maintain thorough dietary records on the patient with specific notations as to the amount of time spent in preparation, conference and telephoning in regard to a particular patient. Miss Piper said that such detailed information has

a side benefit—it will help to justify the need for more personnel.

Dietitians will also be sought to provide nutrition services in interrelated projects, reports Leona Bevis, associate executive director for planning, Welfare Federation of Cleveland. Miss Bevis' paper was read by her associate, Mildred Barry. These projects include nursing homes affiliated with universities and hospitals, public housing centers for aged which are coordinated through local health agencies and hospitals, and diagnostic centers operated in cooperation with nursing homes and chronic disease hospitals in a community.

FOOD TECHNOLOGY

Advances in food technology and new products on the institutional market were topics for two speakers. Jane C. Ebbs, special feeding and nutrition advisor in the Office of the Quartermaster General, Department of the Army, reported on advances in irradiation of foods. She cited the availability of bacon with a 12-month storage life and needing no refrigeration, control of potato sprouting and extension of storage life for apples.

Miss Ebbs said she believes that the addition of chemicals and nutrients has reached the point where we need federal legislation to prevent the overaddition of these elements to foods.

Lendal E. Kotschevar, Ph.D., of the School of Hotel, Restaurant and Institutional Management at Michigan State University, showed individual portions of dehydrofrozen entrees that require only a few minutes submersion in their polyethylene bags in boiling water to bring to serving temperature. Some of these entrees are: lobster newburg, cabbage rolls, ham steak with champagne sauce, chicken aloha, chicken fricassee and beef burgundy. He also noted the availability of such dry freeze products as shrimp, hamburgers, steaks requiring only shelf storage, apples and green beans.

Mr. Kotschevar said that the addition and acceptance of these products will greatly alter kitchen equipment requirements. He cited the experience of one restaurant operator who now utilizes a complete menu of frozen foods. He is using a deep fat fryer for boiling water for reheating entrees because the equipment fabricators haven't developed a unit for such purposes.

FOOD FADDISM

With the public's attention being focused more on food quacks and nutritional "cures", dietitians will have to play an increasingly significant role in nutritional education, according to F. Inistore Godfrey, nutritionist for the Bureau of Health Education, Cleveland Division of Health. Miss Godfrey urged dietitians to disseminate to the public the earmarks of a quack as outlined by the American Medical Association:

1. There is a secret formula for his product.
2. He promises a quick cure.
3. He uses case histories to support his claims for the product.
4. He dwells on the need for medical investigation but does none.

(Continued on next page)

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5. He claims medical men are persecuting him.

6. He insists that surgery, x-ray and drugs will not help the condition.

Miss Godfrey asked dietitians to inform parent-teacher groups on good nutrition, to offer assistance to libraries in selecting good nutritian information, to provide newspapers, magazines and other media with accurate information, and to voice their pros and cons to editors on published material dealing with nutrition.

RESEARCH

One of the more interesting research reports, judging from the meeting's attendance, was the report of a study on heat holding equipment and its effect on food quality and temperature. Dry and wet steam holding equipment were studied at Michigan State University in terms of their effect on seven different classes of foods. Gertrude G. Blaker, associate professor, School of Hotel, Restaurant and Institution Management at Michigan State University, summarized the study's findings as follows:

1. Foods brought to the steam table at 160° F. showed less disintegration after a 2½-hour holding period than foods brought in at 140° F. or below.

2. For whole food items, such as pieces of chicken, which were held in deep containers and prepared and held in one pan, it was easy to attain the 160° F. and hold the food at 140° F.

3. A taste panel indicated that 145° F. was the most acceptable temperature for potatoes, other vegetables and entrees, while 140° F. was the best temperature for desserts and beverages.

Following Miss Blaker's presentation, Anne Donovan sketched recent developments in food service equipment. Miss Donovan is dietary consultant in the Division of Hospital and Medical Facilities of the U.S. Public Health Service. She prefaced her itemization of new equipment items with the statement that a study of 50 to 200-bed hospitals indicates that central tray service and centralized dishwashing dominate in 125-bed hospital dietary operations.

According to Miss Donovan, here are some of the new trends in food service equipment:

1. Mobile conveyor belt table that permits positioning of carts on wheels (holding hot and cold foods) at right angles to the line. There are electrical outlets on the sides of the table for plugging in the mobile carts. It was emphasized that this arrangement has proved particularly adaptable in remodeling programs.

2. Pump attachment in pot and pan sink for automatic scrubbing.

3. Mobile heated and refrigerated cafeteria serving units for use in ambulatory and staff dining rooms.

4. Beverage cart with hot and cold thermal units for use in ambulatory and staff dining rooms.

5. Counter-top trunion kettles.

6. Infra-red broiler.

7. Mobile shelving for reach-in refrigerators. ■

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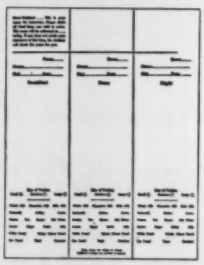

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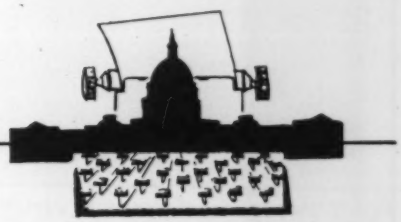

Election's Effect on Legislation Appraised

Immediate post-election appraisals in Washington focused on prospects for Congressional enactment of the legislative program President-elect John F. Kennedy had pledged in his campaign. With the influence of conservative Southern Democrats clearly carrying over into the new Congress and with the re-election of certain key conservative Republicans—the coalition which had defeated the Kennedy program in the post-convention August session of the old Congress—it appeared there would be no easy, quick Congressional approval of the new President's proposals. There was, nevertheless, one significant but still undefined factor in mid-November speculations: The shape and influence of the leadership Mr. Kennedy would exert. Gone, certainly, was the threat of the White House veto which had hung over recent Democratic Congresses.

'NEW FRONTIERS OF HEALTH'

In the health field, Candidate Kennedy had pledged a six-point "New Frontiers of Health" program. It specified: more adequate health care for the aging, based on social security financing; federal grants for new or expanded medical, dental and public health schools; loans and scholarships for students; grants for the renovation of older hospitals; long-term grants for increased medical research, and expanded physical rehabilitation programs.

On the question of more adequate health care for the aging, Mr. Kennedy had promised, just one week before election day, that, if successful, he would propose a program based on social security financing within 30 days after his inauguration. Prospects were good that he would carry out this timetable.

SUPPORTS INCREASED SCHOLARSHIP AID

The President-elect is a strong supporter of increased scholarship aid at the undergraduate level as well as in such specialized fields as medical training. While Vice President Nixon also supported expanded scholarship aid, he had laid emphasis on "private sources".

Hospitals also seemed to be in line for more benefits. Not only had Mr. Kennedy pledged to aid renovation of older hospitals, he also favored such programs as intensified urban renewal, provisions of which might well include construction of new hospitals.

States Take New Actions on Medically Indigent Program

Even prior to election day, it was the opinion of many health experts that, regardless of who won the White House, the August-enacted care program for the medically indigent aged would not only continue but serve as a base for whatever expanded program would be enacted. This appraisal held firm after the election. In fact, with the possibility there would not be speedy Congressional action on a new program, efforts to help the states derive benefits under the 1960 program were stepped up.

Compared to their status in early October (see HOSPITALS, J.A.H.A., Nov. 1, p. 107), several states have since announced their actions on the medically indigent program. West Virginia, which then had enabling legislation in process, has since approved it at a special session of its legislature, presented its program to the Social Security Administration and made appropriations for six months. Michigan, first state to enact needed legislation, has also presented its program to the Social Security Administration and is taking applications in all counties. Oklahoma and New Mexico are drafting plans to go to Washington.

PUERTO RICO ONE OF 'HOPEFULS'

Puerto Rico is reported as one of "the hopefuls," as is Maryland, which has moved from the "prospects doubtful" category. Illinois, after checking its laws, believes it may need legislation to eliminate the residence requirement. Delaware's welfare council, at the request of the governor, is studying the state's needs to participate not only in the program for the medically indigent but also in public assistance health care programs. Tennessee and Utah have moved from "prospects uncertain" to the group indicating they need legal authorization and are planning to seek it. This latter group also now includes the District of Columbia, Hawaii and Washington. Pennsylvania, on the other hand, has shifted from this group to "prospects uncertain". Mississippi, Guam and the Virgin Islands are reported as "prospects doubtful".

THE LAW IN BRIEF

Legal matters of interest to the hospital field prepared by the law department of the American Hospital Association

Overtime Pay in Hospitals

Legislation requiring payment of premium wages after an employee has worked a certain number of hours in a week was passed by the Congress during the depression era. The overtime pay provisions of the federal Fair Labor Standards Act do not specifically refer to hospitals. For years it was assumed, in absence of court decisions, that one or more of the exceptions to coverage by the Act would exempt almost all hospitals.

The most likely statutory exemption is the one applicable to retail and service establishments if over half of their volume of goods and services is sold within the state in which they are located. Few hospitals, whether nonprofit or proprietary, would be found to sell over 50 per cent of their services in interstate commerce. Yet, when the clear test case was litigated, the exemption of hospitals from mandatory overtime pay requirements of the FLSA came on another ground—absence of a direct and essential relationship of the employees' activities to production of goods for interstate commerce.

Huke v. Ancilla Domini Sisters, 267 Fed. 2d 96 (C.A. 7, 1959) was a suit brought against a nonprofit hospital to recover overtime wages on behalf of a fireman who had worked in the institution. The plaintiff sought to establish a sufficient connection between the hospital's activities and production of goods for interstate commerce.

The hospital was located in an industrial area near the borders of three states. Employees of nearby plants utilized the establishment. In fact, seven per cent of the hospital's patients were victims of industrial accidents. The court did not deem this to constitute sufficient evidence of activities affecting interstate commerce. The judges were not unmindful of legal precedent, however. They distinguished the present case from previous cases involving maintenance employees of large office buildings who had been found to be engaged in activities which affected production of goods for commerce. Had those workers refused to operate the elevators, for example, the company headquarters would have ceased to function and ultimately the interstate business of the concerns would grind to a halt.

INDUSTRY NOT DEPENDENT ON HOSPITALS

Hospitals, the court recognized, are generally a purely local activity, although patients may come from more than one state and the patients themselves may be engaged in interstate commerce. But no industry depended on the functions of the fireman or upon the existence of the hospital. Without the hospital, the industry would continue. Hence the hospital and its employees were not considered to have any substantial effect upon the production of goods for interstate commerce.

A related case involved a hospital owned and operated by a large corporation. It cared for employees and their families and for some members of the general public. The court there held the employees of the hospital not entitled to premium overtime pay and other benefits of the FLSA because only 20 per cent of the patients were the company's employees. The other 80 per cent were employees' relatives and members of the public. Therefore, the effect upon interstate commerce was minimal; the hospital was engaged predominantly in rendering local services and the Fair Labor Standards Act did not apply. *Juarez v. Kennecott Copper Corp.,* 225 Fed. 2d 100 (C.A. 10, 1955).

Tort Liability for Noncharitable Activities

Where a nonprofit charitable organization enjoys immunity from liability for negligence, the immunity may end when bingo commences. The highest court in Ohio has so ruled in *Blankenship v. Alter,* 28 Law Week 2625 (Ohio, 1960).

The charity in this case was a church. A patron at a bingo game conducted by the church was injured and brought suit. The defendant contended that as a religious organization it enjoyed charitable immunity from tort liability. (Nonprofit hospitals in Ohio do not enjoy this special status any longer. See HOSPITALS, J.A.H.A., July 1, 1960, p. 121). The court could not agree, noting that the patron was a stranger to any religious or charitable ministrations of the church and might have been allowed to bring her action for this reason alone. But the court preferred to go further. It declared:

> "Immunity from civil liability for negligence accorded to charitable institutions, including religious organizations, depends upon the actual devotion of the institution to charitable purposes, and a charitable institution is liable for negligence in the operation of a business enterprise for profit not directly related to the purpose for which such organization was organized."

The opinion also stated:

"In carrying on the game of bingo for a substantial profit (there was an average of from approximately 1000 to 1500 players at each game session), St. Joseph's Church engaged in a business enterprise disassociated from the purpose

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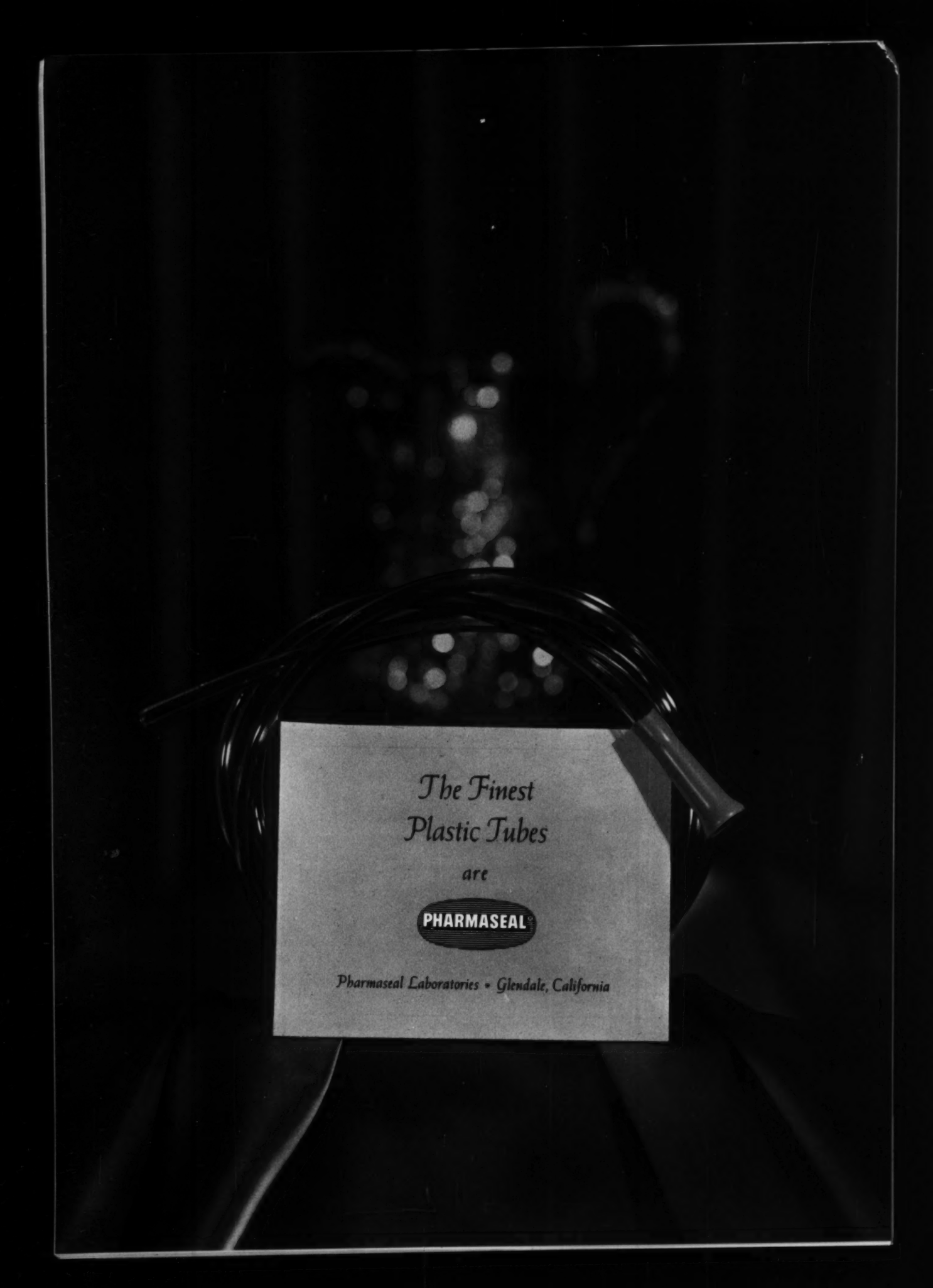
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for which it was organized. By conducting a business enterprise of the kind described, the church removed itself from the protection it might have claimed as a religious and charitable institution. In other words, by conducting the game of bingo as a large-scale, money-making proposition, the church stepped out of its ordinary and accepted sphere and thereby lost the immunity from tort liability it might have asserted in different circumstances."

In other states where hospitals enjoy limited charitable immunity, this decision could be cited by a court wishing to further restrict the immunity status. Thus, large scale fund raising activities featuring games of chance, in addition to their possible income tax consequences (see **HOSPITALS**, J.A.H.A., Jan. 1, 1960, p. 96), may give rise to tort liability. Some liability insurance carriers will cover this risk, however, even in areas where the liability has not yet been recognized by the courts.

TORTS IN THE PARKING LOT

An example of a similar approach to the bounds of charitable immunity is a South Carolina case involving the parking lot of a nonprofit organization. The eleemosynary corporation conducted an agricultural fair and provided a parking lot for its patrons. The plaintiff and her companions were attending a football game held in a stadium owned by the nonprofit entity. The parking fee was fifty cents. She stepped into a hole in the lot and was injured.

Charitable hospitals and other nonprofit ventures have enjoyed immunity from tort liability in South Carolina for at least 45 years. The extent of this protection now has been diminished, however. This case restricts the immunity only to acts committed in the course of the charitable activities. Liability applies to negligent acts arising out of primarily commercial endeavors wholly unconnected with the charitable purpose for which the corporation was organized.

The South Carolina Supreme Court did not conclude that operating the parking lot was an activity unrelated to the defendant's charitable purposes, but referred this question to the trial court to be determined as a matter of fact. *Eiserhardt v. State Agricult. and Mechanical Soc. of S.C.*, 111 S.E. 2d 568 (S.C., 1959).

Hospital Admission: For What Purpose?

Some critics of hospital managements have complained of overutilization of facilities and services by patients. Particularly affected by the increased use of hospitals by the public are health insurance carriers. Blue Cross Plans are even more concerned because they pay for services rather than limiting coverage to stated dollar amounts. Indicative of the problem is a recent, three-way lawsuit involving patient, hospital and Blue Cross Plan.

The patient refused to pay the hospital's bill because he felt that Blue Cross should have covered it. When sued by the hospital, the patient brought Blue Cross in as a defendant. He reasoned that the controversy could best be resolved by the court finding the Blue Cross Plan responsible under the terms of its subscriber contract.

The resistance of Blue Cross was on the ground that the hospital admission was primarily for diagnostic purposes and was thus excluded from coverage under the contract. The trial court, after hearing the evidence, concluded that the patient entered the hospital for treatment not merely diagnosis.

On appeal, the lower court's ruling was reversed and Blue Cross was found to be justified in denying payment. The majority of the court determined that the weight of the evidence showed an admission for diagnostic purposes. *Long Island Hospital v. Hertz: Hertz v. Associated Hospital Service of New York* (App. Div., First Dept., reported in N.Y. Law Journal, March 1, 1960).

CIRCULAR REASONING

This opinion does not settle the difficulty, except perhaps between the participants. Whether a patient is admitted to a hospital primarily for diagnosis or for treatment is a question of fact which must be determined from case to case. Often the purpose of the admission is not clear cut. A patient may enter the hospital facing surgery, but may leave without receiving treatment because inhospital testing so manifests. Hindsight may allow categorizing such an instance as a diagnostic admission. Said a dissenting judge in the Hertz case:

> "(A)ll the tests performed by the hospital could have been performed in the doctor's office, so that respondent (patient) probably went to the hospital for something other than mere diagnosis. The diagnostic tests were merely preparatory to possible surgery."

This jurist evidently preferred to believe that the absence of Blue Cross coverage for tests performed in the doctor's office would not influence the attending physician and this patient in deciding whether to enter the hospital.

FAST WORK

A criminal case tried in a Chicago federal court concerned hospital admissions for surgery which was paid for, but allegedly never performed. The indictment accused the defendant surgeon of using the mails to defraud patients and their health insurance carriers. It was contended that the doctor billed his patients for more extensive surgery than was actually performed and induced the patients to keep coming to his office unnecessarily until they gave up by choice.

The government attempted to prove that in hundreds of cases, the surgeon claimed to have performed operations which could not have been accomplished in the time shown on the hospital records. Expert testimony on either side discussed whether the various operations could have taken as short a period as the surgical charts indicated. It was charged that simple sinus operations were performed while the charts showed lengthy and complicated procedures, and the fees were based on the latter.

The jury's verdict, after five weeks of trial and 6½ hours of deliberation, acquitted the defendant surgeon. *United States v. Schmidt* (U.S. Dist. Ct. N.D. Ill., Jan. 8, 1960).

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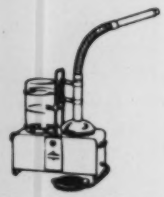

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personnel changes (Continued from page 88)

● **Harold S. Fuller** (see Boyd item).

● **Martin Freiwirth** has been appointed assistant director of Grand Central Hospital, New York City. He is a graduate of the Columbia University program in hospital administration and served his residency at Montefiore Hospital, also in New York.

● **Joseph M. Henry,** executive director of Rochester (N.Y.) Regional Hospital Council for the past eight years, has resigned to accept the position as director of Middlesex General Hospital, New Brunswick, N.J. He was previously administrator of Park Avenue Hospital in Rochester and is a graduate of Northwestern University program in hospital administration.

● **Robert L. Judy** has been appointed assistant to the managing director of Bryn Mawr (Pa.) Hospital. Mr. Judy has been in the hospital field since 1949. He recently received an M.A. in hospital administration from Columbia University after having completed his administrative residency at Jefferson Medical College Hospital, Philadelphia.

● **Paul G. Kibby,** a graduate nurse anesthetist, has been named administrator of Quincy (Wash.) Valley Hospital. Mr. Kibby has served on Naval ships and worked also at Doctors Hospital and Northgate General Hospital, both in Seattle, Wash.

● **Woodrow Lee** has been appointed administrator of McCune-Brooks Hospital, Carthage, Mo., succeeding George Masters, who has retired. Mr. Lee was formerly assistant director of John D. Archibold Memorial Hospital, Thomasville, Ga. He is a graduate of the University of Minnesota program in hospital administration.

● **John J. McDonald** has been appointed administrator of Falmouth (Mass.) Hospital. He previously was the director of Highland Park (Mich.) General Hospital for six years. Mr. McDonald is a graduate of the Columbia University program in hospital administration.

● **John M. McIntyre** has been appointed assistant director for professional services at the Union Memorial Hospital, Baltimore, Md. He was formerly administrative assistant at Strong Memorial Hospital, Rochester, N.Y., and is a graduate of the University of Chicago program in hospital administration.

● **Alfred Muller Jr.** (see Spry item).

● **Francis J. Murphy** (see Bishop item).

● **Col. Frank A. Perri, M.D.,** USAF, MC, has been named commander of U.S. Air Force Hospital and director of Wright-Patterson Air Force Base medical services, Dayton, Ohio. He was formerly deputy commander and director of hospital services at that hospital. A graduate of Jefferson Medical College, Philadelphia, Colonel Perri has served with Air Force bases in Japan, in New York State and in Illinois. He is vice president of the society of Air Force clinical surgeons and president-elect of the society of Air Force clinical surgeons.

● **J. Russell Shawver** (see Case item).

● **Cecile Tracy Spry, R.N.,** has retired after 30 years as administrator of General Hospital of Everett, Wash. She will be succeeded by **Alfred Muller Jr.** who has been assistant administrator at that hospital since 1957. Mr. Muller has an M.A. in hospital administration from the University of California, Berkeley.

● **Sister M. Adelaide** has been assigned as administrator of Saint Anthony's Hospital, Sabetha, Kans. She was formerly administrator of St. Ann's Home, Concordia, Kans. Sister M. Adelaide succeeds **Sister Mary Luke,** who was transferred to St. Joseph's Hospital, Belvidere, Ill.

● **Sister Mary Bernarda, O.S.F., R.N.,** has been appointed administrator of St. Ansgar Hospital, Moorhead, Minn. She holds a B.S. degree in nursing from Marquette University, Milwaukee, and for the past nine years she has been at St. Gabriel's Hospital, Little Falls, Minn., as supervisor in obstetrics and clinical instructor at the hospital school of nursing.

● **Sister Mary Ellen, O.S.F.,** has been appointed administrator of St. Joseph's Hospital, Dodgeville, Wis. She was formerly assistant administrator of St. Gabriel's Hospital, Little Falls, Minn.

● **Sister Mary Evangeline, O.S.F.,** has been appointed administrator of St. Michael's Hospital, Sauk Centre, Minn., succeeding **Sister Mary Avelline, O.S.F.**

● **Sister M. Fabiola, P.H.J.C., R.N.,** has been named assistant administrator of St. Elizabeth's Hospital, Chicago. She has formerly served at that hospital for four years as surgical supervisor, prior to receiving her M.A. in hospital administation from St. Louis University. She also holds a B.S. degree in nursing education from that university.

● **Sister Grace Francis, S.F.P.,** assistant administrator of St. Clare's Hospital, Schenectady, N.Y., has left her post to complete studies at St. John's University, Jamaica, Long Island, N.Y., for a degree in business administration. She will be assisted by **Sister Mary Martin, S.F.P.** Sister Grace Francis joined the staff of St. Clare's Hospital in 1956 as supervisor of accounting. She is vice president of the Northeastern New York Chapter of the American Association of Hospital Accountants. Sister Mary Martin was formerly

business administrator at St. Anthony's Hospital, Warwick, N.Y.

● **Craig S. Slater** has been promoted from assistant administrator to administrator of the Beverly (Mass.) Hospital, succeeding **Mae Bartley,** who resigned. Mr. Slater was formerly administrative assistant at Mary Fletcher Hospital, Burlington, Vt. He is a graduate of the Yale University course in hospital administration.

● **Edward P. Street** (see Bogia item).

Deaths

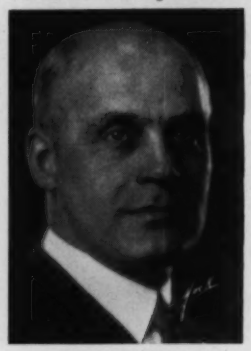
Ralph Falk, M.D., 76, founder and chairman of the board of Baxter Laboratories, Inc., Morton Grove, Ill., and pioneer in the development of intravenous feeding, died November 2 in Chicago.

Dr. Falk was born in Boise, Idaho, Aug. 6, 1884. He received his medical degree in 1907 from Jefferson Medical College in Philadelphia and was on the staff of St. Alphonsus and St. Luke's hospitals there for 32 years. He practiced surgery until recent years and was a Fellow of the American College of Surgeons.

Mother Mary Alice, 81, founder of St. Clare's Hospital, New York City, 26 years ago, died November 7. She served as administrator of St. Clare's until five years ago, and during her administrative career won several awards and honors for her efforts on behalf of the sick and needy.

Born in Ireland, she came to the United States as a young girl and entered the Sister of the Third Order of St. Francis in Allegany, N.Y.

Christopher G. Parnall, M.D., 80, past president of the American Hospital Association, died November 6, in Ann Arbor, Mich. A graduate of the University of Michigan Medical School in 1904, Dr. Parnall served as a director of University Hospital from 1918-1924, and was medical director of Rochester General Hospital from 1925 until his retirement in 1945.



DR. PARNALL

Dr. Parnall was a diplomate of the American Board of Preventive Medicine and Public Health, a fellow of the American Medical Association, and a member of many organizations including the American College of Physicians, the American Public Health Association, the American Association of Hospital Consultants and the Society of Medical Administrators. He was president of the American Hospital Association in 1929.

Dr. Parnall was known for hospital planning and his pioneer concepts in hospital administration. He did the functional planning for the University of Iowa Medical School, Iowa City, and planned hospitals for the University of Texas, Baylor University, the Harrisburg Polyclinic, the Eli Lilly Clinical Laboratories, and city and county hospitals of Houston, Tex.

In 1958 he was given the University of Michigan Award for Hospital Administration.

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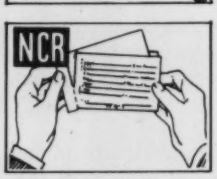

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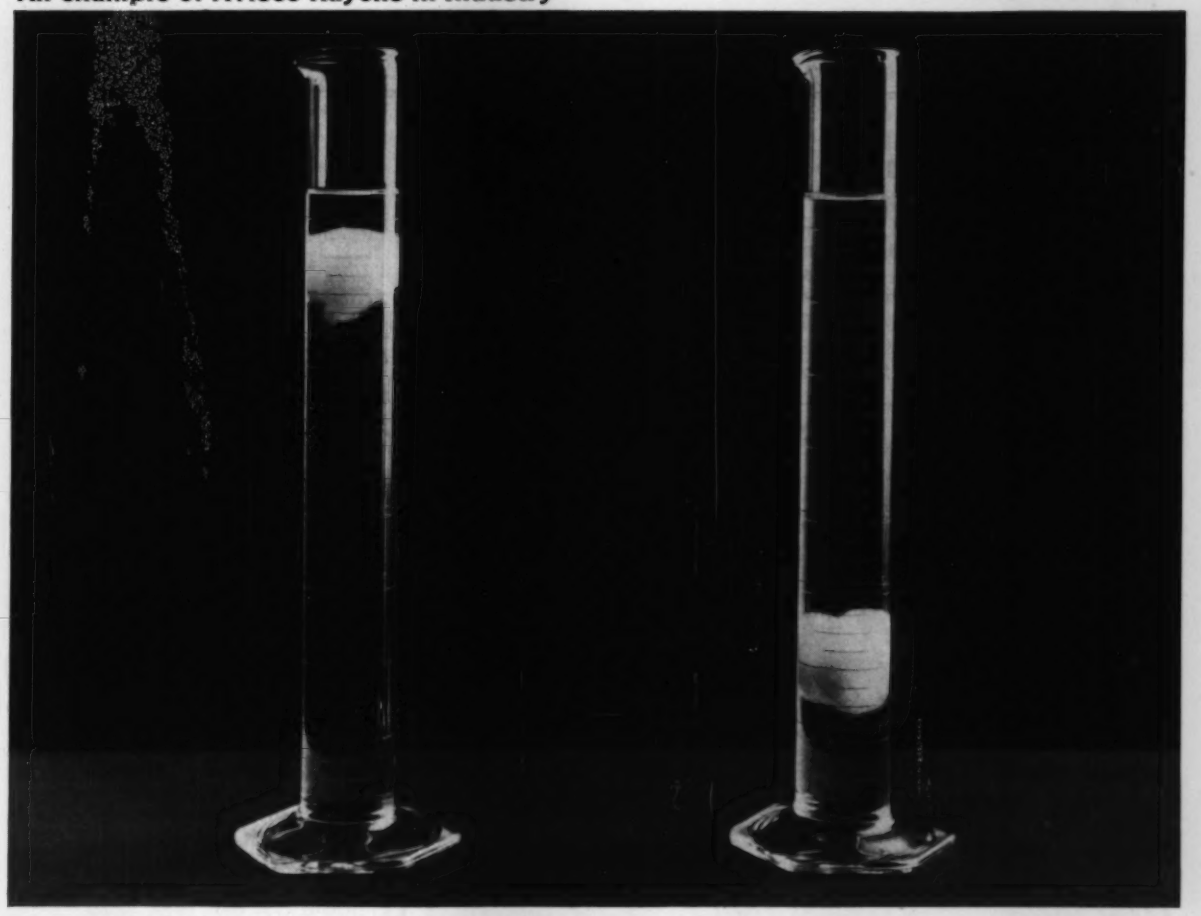

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Experience Rating Debated by Blue Cross At Four New Jersey Legislative Hearings

Testimony on a bill which would permit New Jersey Blue Cross to issue master contracts for group subscribers, engage in the writing of national Blue Cross accounts and undertake experience rating for New Jersey groups with over 100 subscribers, was considered at four hearings held by the Special Legislative Commission to Study New Jersey Blue Cross. The six-member commission, headed by Senator Wayne Dumont Jr. (R.-Warren), has conducted three hearings and several more are anticipated before the commission completes its work.

Whether to approve experience rating, the system under which New Jersey Blue Cross proposes to assess payments for groups with over 100 subscribers on the basis of the group's utilization of hospital services during the previous year, has been the major controversy of all the hearings thus far. Under the existing law, the New Jersey Plan is required to engage in community rating, the system under which all subscribers within the whole community pay the same rates as all others in the same category.

RATING BASED ON NORM

Under experience rating, the Plan proposes to use the existing group rates as the 100 per cent norm, downgrading or upgrading rates for specific groups on this basis. Groups with the best experience would be rated, or charged, up to 75 per cent level, while those with the highest utilization records would be rated up to the 125 per cent level.

Arguments in favor of experience rating were presented to the commission at the second public hearing by Milton O. Loysen, New Jersey Blue Cross vice president in charge of internal relations. He declared that without experience rating the Plan would continue to lose low-loss accounts to commercial insurance companies and would be left with the high-loss accounts, thus endangering its financial structure.

In opposition to the Blue Cross stand, J. Harold Johnston, executive director of the New Jersey Hospital Association, read a resolution adopted by the hospital association in July 1960, which states that the voluntary hospitals of New Jersey will continue to support Blue Cross so long as it continues to fulfill its "unique and special mission" (assisting people to protect themselves against the unexpected costs of illness).

In effect, the resolution points out that if Blue Cross becomes just

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another insurance company and adopts policies for the primary purpose of meeting the competition, the justification for the present relationship between the Plan and hospitals would cease to exist.

The resolution contends that experience rating will in no way decrease or stabilize the total amount of money which Blue Cross must collect from subscribers to reimburse the hospitals. The result will only be a redistribution of Blue Cross rates among its subscribers, which will work to the disadvantage of groups that include individuals in the upper-age bracket and others who can least afford higher rates.

HEAR TESTIMONY

Among those testifying at the third hearing was Emmanual Mann, international representative of the United Auto Workers-CIO. He told the commission that experience rating is not in the best interest of the community and if Blue Cross adopts this system his union would have to "start looking" for an alternate plan from which to purchase service benefits.

Martin Segal, president of Martin Segal, Inc., N.Y., consultants on employee benefit plans, testified in favor of experience rating. He said that although he personally believes in community rating from a philosophical point of view, the "facts" make it necessary for Blue Cross to engage in experience rating. He also acknowledged that experience rating would impose a hardship on some group subscribers, but he added that it would remove a hardship from low-risk groups.

The commission also heard testimony by Richard Fondiller, consulting actuary to Blue Cross; George Heitler, secretary and staff counsel to the National Blue Cross Association, and Richard C. Brockway, executive director of Massachusetts Blue Cross, which has followed the practice of experience rating since 1951. ■

St. Louis Hospital Council Reorganizes and Expands

The reorganization of the Greater St. Louis Hospital Council into the Hospital Association of Metropolitan St. Louis has been announced by the council.

The new association will include hospitals of the city and county of St. Louis, and hospitals of the counties of Illinois and Missouri surrounding the St. Louis area. There are presently 43 hospitals in the hospital association. Representative of boards of trustees and lay advisory boards of member hospitals will be included in the new hospital association.

David Littauer, M.D., executive director of Jewish Hospital, St. Louis, is president of the association. ■

New FCC Eligibility Ruling Grants Emergency Radio Frequencies to Hospitals

The Federal Communications Commission (FCC) has announced new rules expanding eligibility in the Special Emergency Radio Service to include hospitals and ambulances. The new rules, effective Dec. 1, 1960, set aside five radio channels in the 150 megacycle bands for the exclusive use of hospitals and ambulances. Hospitals may share with others addi-

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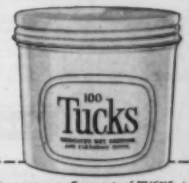
but certainly not as a toilet wipe when anal areas are sensitive. Unlike harsh, dry wood pulp toilet papers, *Tucks* are soft cotton flannel pads mildly medicated with witch hazel (50%) and glycerin (10%). *Tucks* are ideal for routine toilet care when treating pruritus ani et vulvae, diaper rash, hemorrhoids, following episiotomy or hemorrhoidectomy, and in other anorectal conditions. *Tucks* cleansing, mildly astringent action hastens healing and helps assure patient comfort. *Tucks* are available at busy *prescription pharmacies* everywhere in jars of 40 and 100.



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tional frequencies assigned to the Special Emergency Radio Service.

The FCC has also expanded radio communications to include urban as well as rural physicians. The commission stated that "extending eligibility to include urban as well as rural physicians employing all presently available Special Emergency frequencies plus eight new ones will result in the establishment of radio communications systems adequate to meet the needs of that segment of the medical profession."

The ruling authorizes hospital radio use in day-to-day activities and in the time of disaster, for the "transmission of messages necessary for the rendition of an effective hospital service," and permits radio communications between hospitals and mobile units, and between hospitals.

Following are the restrictions stated by the commission:

- *Eligibility.* Eligible hospitals are those institutions or establishments offering services, facilities, and beds for use beyond 24 hours in rendering medical treatment.
- *Application.* The initial application must be accompanied by a statement describing the radio communication facilities desired, the area to be served, the proposed method of operation and the number and classes of stations required.
- *Classes and number of stations available.* Each eligible hospital will normally be authorized only one base station and a number of mobile units, not in excess of vehicles actually engaged in rendering an efficient hospital service.
- *Permissible communications.* Except for the test transmissions permitted, stations licensed to hospitals may be used only for the transmission of messages necessary for the rendition of an efficient hospital service.

With regard to physicians and veterinarians, the new rules state:

- *Eligibility.* "Physician" and "Veterinarian" mean individual physicians and veterinarians or schools of medicine or veterinary medicine.
- *Application.* The application must be accompanied by a statement of the applicant's eligibility.

The FCC's new rules climax an intensive drive by the American Hospital Association, begun more than three years ago, to secure eligibility standards and reserved frequencies adequate to meet the radio needs of hospitals. Except for minor variations, the commission's new rules are the same as those proposed by AHA. ■

There is more to Fund-Raising than Raising Funds

When a hospital must raise money for new or expanded facilities, those in charge face the problem of raising the funds in a manner that will not endanger the hospital's standing and respect in the community.

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Hospital-Community Growth Correlated in U.C.L.A. Study

A definite correlation between the hospital, the community in which it is located, and a small number of adjacent communities is indicated in results of a study recently completed by the University of California Bureau of Governmental Research.

The study, "Hospital Development and Communities," by Beatrice Dinerman, public administration analyst, compared the growth patterns of hospitals in established areas with those of fast-growing, newer areas. The study was limited to nongovernmental hospitals in the Western and San Fernando Valley sections of Los Angeles County.

Results of the study show that the establishment of any service institution reflects the existence

of a "community" in the area (1) if it is established in response to a need as expressed by inhabitants of the area in which the institution is located; (2) if these inhabitants constitute a group large enough to support its services, and (3) if it receives its support largely from this group and exists for the major purpose of serving the needs of this group.

Applying these factors to hospitals, it was found that (1) they are established in response to a need as expressed, in this case, by physicians practicing in the area, although the area is generally greater than the boundaries of the immediate community in which the hospital is located; (2) inhabitants of the immediate vicinity do not always constitute a group large enough to support its services, and (3) hospitals do not generally exist for the major purpose of serving the health needs of inhabitants in the immediate vicinity in which the hospital is located.

"In the light of these considerations, it would seem that hospital care represents one type of service with no exclusive relationship to the community in which the services are rendered. Yet, there would seem to be a definite relationship between the hospital, the community in which it is located, and a small number of adjacent communities, with total service coverage rarely exceeding a ten-mile radius," the study concludes.

An interesting sidelight of the study was that "virtually every hospital administrator interviewed . . . indicated the need for some type of advisory body responsible for hospital planning on a regional basis." ■

Milwaukee Plan Designed To Conserve Hospital Use

A five-point program to conserve hospital-medical resources in the Milwaukee area has been launched by the Medical Society of Milwaukee County, the Milwaukee hospitals, Blue Cross and Surgical Care Blue Shield.

The program is a result of an intensive three-month study of the use of hospital facilities and medical resources by 21 hospitals in the Milwaukee area which was undertaken in the fall of 1959.

The five major recommendations are:

1. Creation of a hospital utilization committee composed of hospital medical staff members to analyze and make recommendations on the use of hospital facilities by the medical staff, and on the necessity of admissions and length of patient stay.

2. Review of health insurance utilization reports by a joint Blue Cross-Surgical Care conference committee, which would recommend policy for guidance of medical review department and work with the hospital utilization committee in each hospital.

3. Establishment of an educational program for physicians by the Medical Society of Milwaukee County on the conservation of medical and hospital resources.

4. Expansion in scope of surgical care (Blue Shield) contracts so that physicians will not be inclined to hospitalize patients with hospital insurance for diagnostic work which would be performed outside the hospital.

5. Establishment of a public educational program, directed at the individual health insurance subscriber, regarding proper and economical use of such insurance.

The plan, which has been approved by a special committee of the Hospital Council of Greater

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Milwaukee, as well as the medical society and Blue Cross boards, is a preventive program rather than remedial. Although widespread overutilization and misutilization have been reported in various parts of the country, the findings of the Milwaukee survey "do not indicate serious or widespread abuse here." ■

Financial Aid Program Asked for Medical Students

A total national effort to provide financial assistance for medical students, to cost $86,000,000 over the next five years, was called for at the 71st annual meeting of the Association of American Medical Colleges (AAMC) recently. Based on a report made by a special committee of the AAMC, the proposal is aimed at solving the dual problem of declining medical school applications and the rising cost of medical education.

Comparing medical student costs to those of Ph.D. students, it was noted that the medical student pays more than twice as much, and receives only one fourth the financial assistance.

The report summarized: "Personal need is a bar to the study of medicine in this country and a positive program of financial assistance to medical students is needed to eliminate the situation." ■

PHS Announces New Courses in Short-Term Nursing Series

A new supplemental list of agencies sponsoring federally supported short-term intensive training courses for nurse administrators, supervisors and teachers has been issued by the U.S. Public Health Service. (Previous lists have appeared in the April 1, May 16 and June 16 issues of this Journal.)

The following additions have been announced:

School of Nursing, Evansville (Ind.) *College.* Director: Mildred Boeke, director. **(1)** Subject: Effective Nursing Supervision. Dates: Jan. 25—Feb. 9, 1961 (exact dates of each session to be determined). **(2)** Subject: Improving the Quality of Nursing Care Through Team Nursing. Dates: March 1-16, 1961 (exact dates of each session to be determined). **(3)** Subject: Selected Methods of Teaching in Nursing. Dates: Nov. 30—Dec. 1, 1960; Dec. 7-8, 1960; Dec. 14-15; 1960 (to be given in three sessions for the same group.)

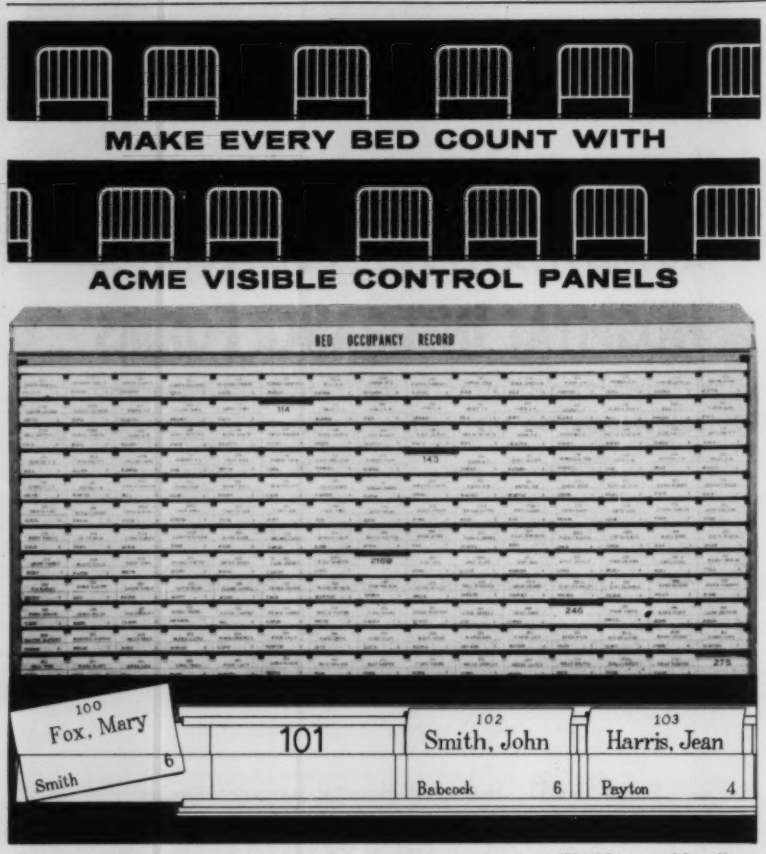
College of Nursing, State University of Iowa, Iowa City. Director: Pearl Zemlicka, assistant professor. **(1)** Subject: Practical Nursing Program Development. Dates: June 12-16, 1961. **(2)** Subject: Evaluation of Learning in Nursing. Dates: April 17-21, 1961.

School of Nursing, University of Maryland, Baltimore. Director: Florence M. Gipe, dean. Subject: Supervision in Nursing. Dates: Nov. 28—Dec. 9, 1960.

School of Nursing, University of Michigan, Ann Arbor. Director: Theresa Phelps, assistant professor of nursing. **(1)** Subject: Aspects of Evaluation for Supervision. Dates: March 13-17, 1961. **(2)** Subject: Methods of Instruction for Teachers in Schools of Nursing. Dates: Jan. 16-27, 1961 (to be repeated May 8-19, 1961).

Rutgers, The State University, Newark, N.J. Director: Mrs. Ann L. Clark, chairman, department of obstetric nursing. Subject. Counseling and Teaching in Maternal-Child Nursing. Dates: Jan. 9-13, 1961.

Division of Nursing Education, University of Rochester, Rochester,



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N.Y. Director: Esther M. Thompson, chairman. (1) Subject: Management in Nursing. Dates: May 15-20, 1961. (2) Subject: Teaching the Teacher How to Teach Operating Room Technicians. Dates: Nov. 28—Dec. 3, 1960.

Frances Payne Bolton School of Nursing, Western Reserve University, Cleveland, Ohio. Director: Mrs. Ida S. Strieter, chairman, committee on graduate nurse programs. Subject: Promoting Improved Care of Patients with Long-Term Illnesses. Dates: April 17-28, 1961.

Continuing Education Services, The Pennsylvania State University, University Park. Director: Mrs. Ruth W. McHenry, coordinator of nursing education. (1) Subject: Improvement of Nursing Services in Hospitals Through Guidance of Directors and Assistant Directors of These Services. Dates: Jan. 15-20, 1961. (2) Subject: Improvement of Nursing Services in Hospitals Through Guidance of Nursing Supervisors. Dates: Nov. 27—Dec. 2, 1960 (to be repeated Feb. 26—Mar. 3, 1961 and April 9-14, 1961).

School of Nursing, University of Pittsburgh, Pa. Director: Mrs. Ruth Perkins Kuehn, dean. Subject: Work Conference: Pediatric Nursing in the Diploma Program. Dates: Dec. 1-3, 1960.

Texas League for Nursing, Inc., Austin. Director: Ruth L. Smith. Subject: Nursing Management Skills. Dates: Dec. 5-9, 1960 (in Houston). Dates of second and third workshops in each region to be announced later.

Department of Nursing, Clark College, Vancouver, Wash. Director: Mrs. Helen M. Donovan. Subject: Work Conference: Nursing Service Administration. Dates: Dec. 7-8, 1960 and Jan. 11-12, 1961.

"Facts About the Professional Nurse Traineeship Program", a pamphlet recently released by the Division of Nursing, U.S. Public Health Service, contains information on programs and eligibility requirements for applicants. It may be obtained from the Division of Nursing, Public Health Service, U.S. Department of Public Health, Education, and Welfare, Washington 25, D.C. ■

PHS Grants Channel $7 million to Health Fields

New grants announced by the Public Health Service are providing more than $7,100,000 for the establishment of clinical research centers, for research in various aspects of aging, for nursing projects and nursing research training and for the first projects under the new law providing for graduate training in public health.

Twenty-three higher education schools in 18 states and in the District of Columbia received the public health graduate training grants, which were made possible by legislation enacted by the 86th Congress in its closing August session. There are 24 projects in these first grants which total $470,611.

The new nursing grants provide approximately $200,000 for six new research projects and around $75,000 for 16 new predoctoral fellowships for training in nursing research. The grants for research in various aspects of aging total $1,869,027; there are 94 of these grants to private institutions, including 11 hospitals. Under the clinical research centers program, grants totaling $4,509,702 were made for the establishment of 11 new centers in private research institutions, including Harvard Medical School's Peter Bent Brigham Hospital in Boston.

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Oregon Association of Hospitals: president, E. E. Beitz, administrator of Portland Sanitarium and Hospital; president-elect, Selmer O. Kivle, administrator of The Good Shepherd Hospital, Hermiston; vice president, Sister Marie de Pazzi, administrator of Sacred Heart General Hospital, Eugene, and secretary-treasurer, P. D. Fleissner, administrator of McKenzie-Willamette Memorial Hospital, Springfield.

Vermont Hospital Association: president, Joel Walker, administrator of Barre City Hospital; president-elect, Leslie Morse, administrator of Gifford Memorial Hospital, Randolph; secretary, Thomas Hennessey, administrator of Springfield Hospital, and treasurer, Frederick A. Hale, controller at Mary Fletcher Hospital, Burlington.

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Hospital association meetings

(Continued from page 6)

20-22 New England Hospital Assembly, Boston (Hotel Statler)
20-23 **Obstetrical Nursing Administration,** Los Angeles (Statler Hilton Hotel)
21-23 Kentucky Hospital Association, Lexington
23-24 Georgia Hospital Association, Atlanta (Biltmore Hotel)
27-29 **Methods Improvement (Advanced),** Chicago (AHA Headquarters)

APRIL

4-7 Ohio Hospital Association, Columbus
5-7 **Capital Financing of Hospitals,** Chicago (AHA Headquarters)
10-14 *National League for Nursing,* Cleveland
12-14 **Labor Relations,** Chicago (AHA Headquarters)
13-14 Carolinas-Virginias Hospital Conference, Roanoke (Hotel Roanoke)
19-21 Quebec Hospital Association, Montreal (Queen Elizabeth Hotel)
19-21 **Hospital Librarianship,** Chicago (AHA Headquarters)
19-21 Southeastern Hospital Conference, Memphis (Municipal Auditorium)
24-27 Association of Western Hospitals, San Francisco (Civic Auditorium)
24-27 **Nursing Inservice Programs,** New York City (Sheraton-Atlantic Hotel)
24-28 **Medical Record Librarians, on Principles of Medical Record Management (Advanced),** Chicago (AHA Headquarters)
24-28 *National Association for Practical Nurse Education and Service,* Detroit (Statler Hilton Hotel)
25-28 **Hospital Engineering,** Dallas, Tex. (Adolphus Hotel)
26-27 Iowa Hospital Association, Des Moines (Fort Des Moines Hotel)
26-28 Midwest Hospital Association, Kansas City (Municipal Auditorium)

MAY

1-3 Tri-State Hospital Assembly, Chicago (Palmer House)
8-10 **Hospital Organization,** New York (Sheraton-Atlantic Hotel)
9-12 **Nursing Home Administration,** Omaha, Nebr. (Sheraton-Fontenelle Hotel)
10-12 Upper Midwest Hospital Conference, Minneapolis
11 Massachusetts Hospital Assembly, Boston (Statler Hotel)
14-17 Texas Hospital Association, Dallas (Memorial Auditorium)
15-18 **Hospital Dental Service (Basic),** Boston (Somerset Hotel)
15-19 **Occupational Therapists,** Washington, D.C. (Willard Hotel)
17-19 Hospital Association of New York State, Atlantic City, N.J.
17-19 Middle Atlantic Hospital Assembly, Atlantic City, N.J. (Convention Hall)
17-19 New Mexico Hospital Association, Albuquerque (Western Skies Hotel)
22-25 **Evening and Night Nursing Service,** Detroit (Pick-Fort Shelby Hotel)
22-26 **Shared Dietitian and Dietary Consultant,** Chicago (AHA Headquarters)
23-24 **Credits and Collections,** Atlanta (Henry Grady Hotel)
26-27 Tennessee Hospital Association, Gatlinburg (Riverside Hotel)

Opinions and ideas

(Continued from page 28)

formation for the medical record should be reported to the medical record committee so that appropriate action can be taken." At Hudson Memorial Hospital the report goes to the president of the medical staff rather than to the medical record committee.

Since this suspension program was set up at our hospital, the number of incomplete charts has been drastically reduced. Histories and physicals appear on the chart promptly after the admission of the patient. Medical records are completed soon after the patient's dismissal.

We believe that our program is satisfactorily achieving the desired results. We would recommend it to any hospital having the problem of getting medical records completed satisfactorily.—MRS. LUELLA T. PENNER, *registered record librarian, Hudson (Wis.) Memorial Hospital.* ■

Introducing the authors

(Continued from page 12)

Cornell as assistant professor of public health and to the New York Hospital as assistant attending physician—positions which he stills holds.

His principal research interest has been directed toward the application of epidemiologic techniques to such areas as emergency medical care, coronary artery disease and automobile accidents. Dr. McCarroll has recently been commissioned by the U.S. Public Health Service to develop a manual of simplified treatment procedures for training professional and nonprofessional medical personnel in the care of mass casualties.

Dr. McCarroll is a fellow of the American Public Health Association and a member of the committee on public health, New York County Medical Society.

At present Dr. Skudder is assisting attending surgeon and surgeon to the emergency unit at New York Hospital as well as assistant professor of clinical surgery at Cornell University Medical College, New York.

Both Dr. Skudder and Dr. McCarroll are currently working closely with the American Hospital Association Committee on Hospital Outpatient Services on the preparation of a manual on emergency outpatient services. Dr. Skudder's other organizational activities include membership on the public health committee of the New York County Medical Society.

Dr. Skudder received his A.B. degree from Middlebury (Vt.) College in 1949 and his M.D. degree from Cornell University Medical College, New York, in 1953. He completed his internship and part of his residency training in surgery at the New York Hospital-Cornell University Medical Center. He also served as a surgical resident at University Hospital, Madison, Wis.

Dr. Skudder is a diplomate of both the National Board of Medical Examiners and the American Board of Surgery, Inc.

Editorial notes

(Continued from page 33)

for which the patient is to be treated.

In short, no hospital should permit a lay person to exercise hypnotic techniques in the medical or surgical care of patients. In some areas, lay persons are applying to hospitals for permission to hypnotize patients for surgery or delivery. Such requests should be flatly refused.

When employed by physicians, hypnotic techniques should be used for purposes that are related to the physician's particular specialty and for procedures that are within the range of his ordinary professional competence.

Hospital medical staffs must permit only those members to use hypnosis who are qualified to do so and only for such purposes and procedures as they are professionally competent to perform. No physician should use hypnosis unless the patient has already had an adequate physical—and if indicated, a mental—examination.

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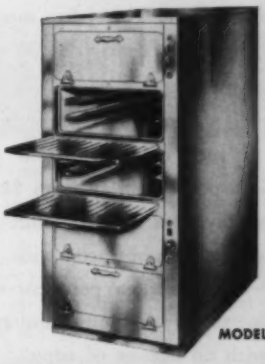

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Chicago 11, Illinois

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ADMINISTRATIVE PERSONNEL: (a) Dir. Public Relations, renowned N.Y. research hosp; (b) Bus. Mgr., new hosp, 50 beds, near Atlantic ocean resorts; (c) Controller, 350 bed hosp, commuting distance N.Y.C., $9000; (d) Purch Agent; organize dept; 500 bed hosp, winter spa, to $9000; (e) Personnel Mgr., 200 bed hosp, initiate dept. suburb, Ohio. H 12-2.

ANESTHETISTS: (a) Anes. responsible for entire service, 55 bed hosp. near Ozarks, to $9000; (b) Anes. join group clinic anesthesiologists; beautiful college town, Iowa, $8500; (c) Anes. direct 15 bed hosp. Alaska seaport, good financial opport. H 12-3.

DIETITIANS: (a) Chief, 450 bed hosp. exc. opport. exercise initiative; $7200; (b) Dietitian, need not be A.D.A., small brand new hosp. E. $5000 up; (c) Dietitian, one year contract, well renowned Australian hosp. near univ., beaches; H 12-4.

DIRECTORS OF NURSING: (a) Direct nursing service all grad. staff, 400 bed hosp., San Francisco Bay area, to $12,000; (b) Direct nurs. services, large school, 425 bed hosp. commuting distance, Wash. D.C., $10,000; (c) Male Dir. of Nurses, 375 bed gen. hosp. excellent financial opport. for ambitious well qualified man. S. H 12-5.

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Chicago 11, Illinois

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ADMINISTRATOR, M.H.A. 4 years experience Assoc. Dir. tchg. hosp. assisted building program inc. capacity 200-400 beds; 6 years exp. Dir. 225 bed hospital.

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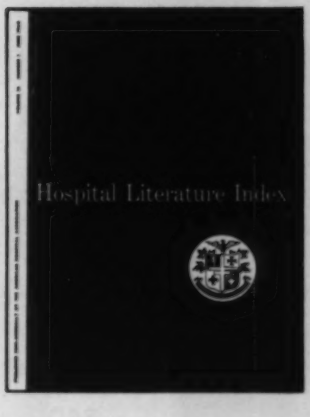

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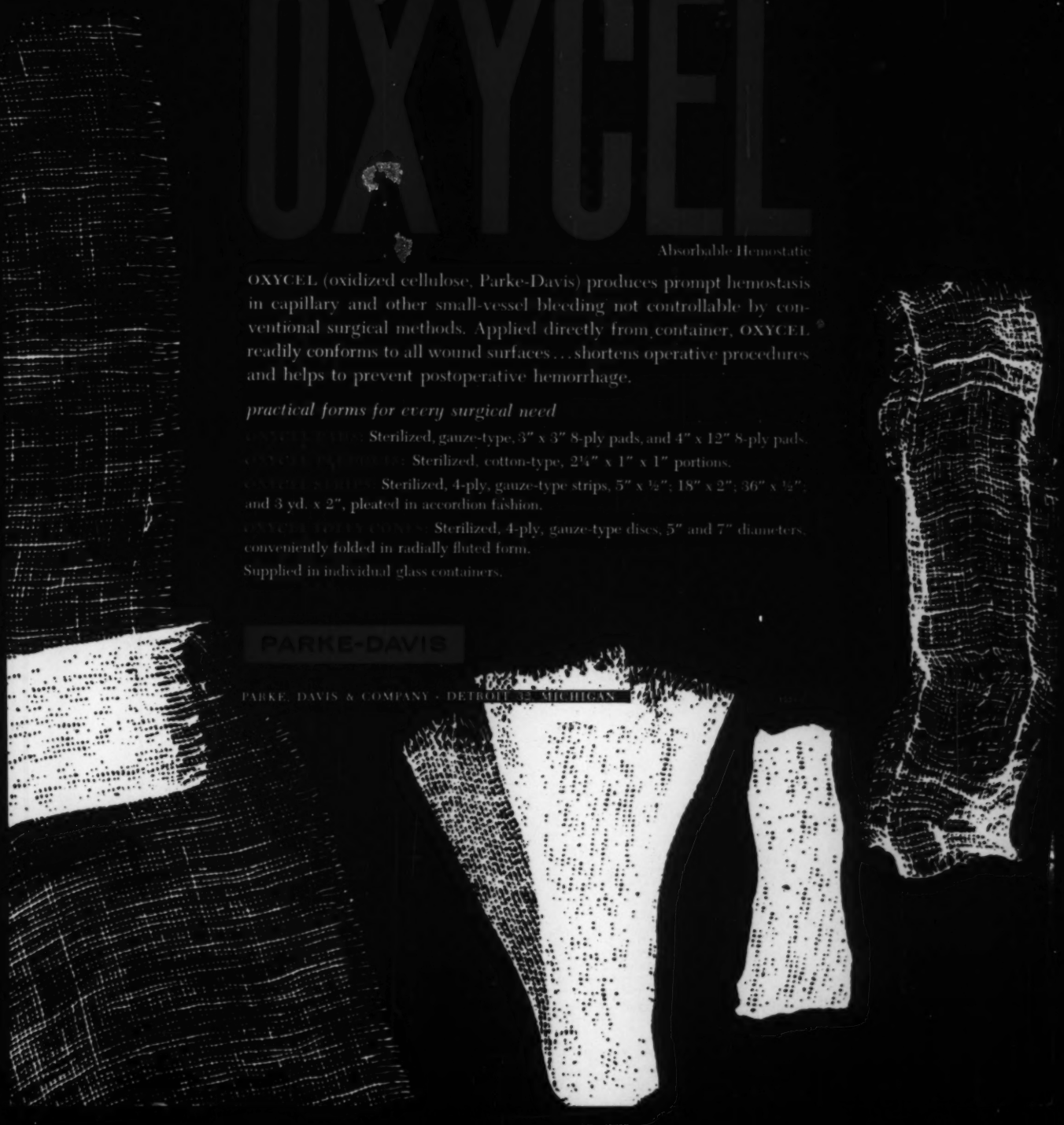

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